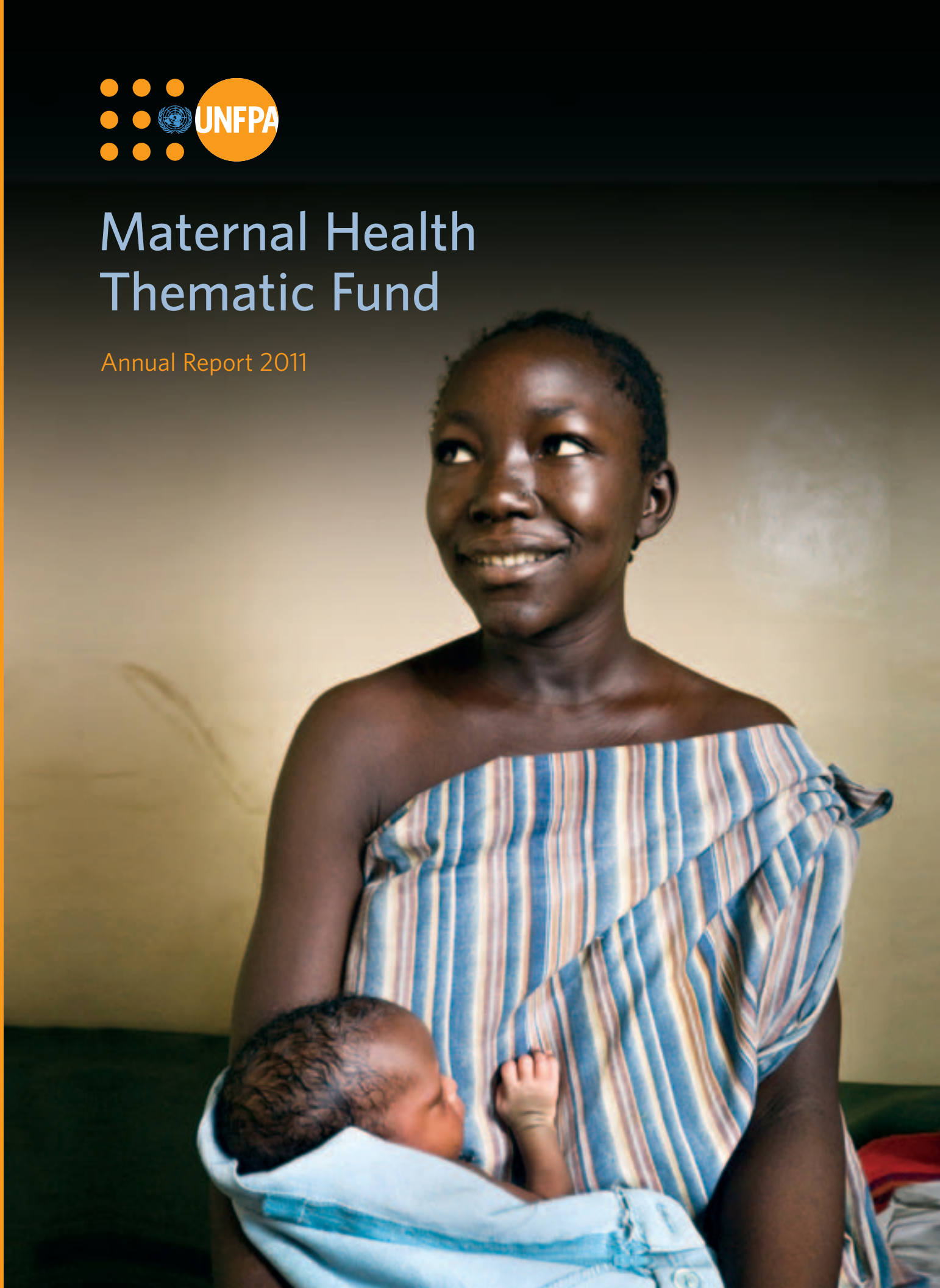
Maternal Health Thematic Fund

Annual Report 2011



UNFPA:
Delivering a world where every pregnancy is wanted, every childbirth is safe, and every young person's potential is fulfilled.

Cover photo: A young woman and her healthy, newborn baby following a Caesarian section in Central Equatoria, South Sudan. Photo by Sven Torfinn, Panos Pictures.

ACKNOWLEDGEMENTS

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Finally, we would like to acknowledge the hard-working team in the UNFPA Sexual and Reproductive Health Branch, the Commodity Security Branch, other colleagues in the Technical Division, colleagues in the Resource Mobilization Branch, the Media and Communication Branch, Finance Branch, other UNFPA units and members of the Maternal Health Inter-Divisional Working Group for their commitment, solidarity and teamwork in promoting maternal and newborn health and for their contributions to this report.

We look forward to continuing this productive collaboration and to our active participation in the future.

ACRONYMS & ABBREVIATIONS

AMDD	Averting Maternal Death and Disability Program (Columbia University)
DFID	Department for International Development (United Kingdom)
EmONC	Emergency obstetric and newborn care
FIGO	International Federation of Gynecology and Obstetrics
H4+	WHO, UNICEF, UNFPA, the World Bank and UNAIDS
ICM	International Confederation of Midwives
INGO	International non-governmental organization
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDG	Millennium Development Goal
MDSR	Maternal death surveillance and response
MHTF	Maternal Health Thematic Fund
NGO	Non-governmental organization
UNAIDS	Joint United Nations Programme for HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

FOREWORD

by Dr. Babatunde Osotimehin – Executive Director, UNFPA

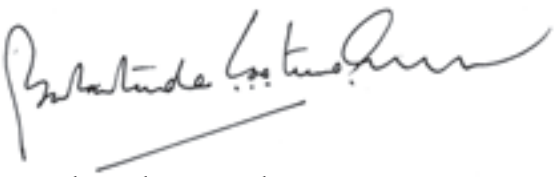
Delivering a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled is a mission that demands a comprehensive approach to sexual and reproductive health and reproductive rights. UNFPA, the United Nations Population Fund, is a trusted development partner working in close collaboration with governments, non-government and civil society organizations, cultural and religious leaders and other stakeholders and valued partners. UNFPA works in 155 countries, with field offices in 128 countries.

As the leader in the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), UNFPA gives priority to two key targets of the Millennium Development Goals (MDGs): reducing maternal deaths and achieving universal access to reproductive health, including voluntary family planning. UNFPA launched two thematic funds to accelerate progress by catalyzing national action and scaling up interventions in critical areas.

The Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) has mobilized $450 million since 2007 to ensure access to a reliable supply of contraceptives, condoms, medicines and equipment for family planning, HIV/STI prevention and maternal health. In 2011, the Global Programme provided pivotal and strategic support for the procurement of essential supplies and for capacity development to strengthen national health systems in 46 countries. In less than five years, countries began reporting impressive results: more couples are able to realize their right to family planning, more health centres are stocked with contraceptives and life-saving maternal health medicines, family planning is increasingly being prioritized at the highest levels of national policies, plans and programmes, and more governments are allocating domestic resources for contraceptives.

The Maternal Health Thematic Fund (MHTF) supports high maternal mortality countries to accelerate progress in reducing the number of women who die giving birth and in reducing associated morbidity. Its evidence-based business plan focuses on: emergency obstetric and newborn care; human resources for health, particularly through the Midwifery Programme; and the prevention and treatment of obstetric fistula, leading the Global Campaign to End Fistula. Together with GPRHCS, it also fosters HIV integration and supports synergistically specific areas of family planning in some countries. Supplementing UNFPA's core funds, the MHTF has mobilized $100 million since its inception in 2008 and currently provides strategic support to 43 countries.

Working together, these initiatives support the UN Secretary-General's Global Strategy for Women's and Children's Health and are engaged in the UN Commission on Life-Saving Commodities for Women and Children. These and other actions are placing maternal health high on national and global agendas. The many achievements featured in this report demonstrate the importance of strong political commitment, adequate investments and enduring partnerships. I would like to take this opportunity to thank countries, donors, other partner organizations and all colleagues for their productive collaboration now and in the future.



Dr. Babatunde Osotimehin
Executive Director, UNFPA

EXECUTIVE SUMMARY

To accelerate improvements in maternal and newborn health and progress towards Millennium Development Goal 5, UNFPA (the United Nations Population Fund) launched two thematic funds to provide additional support to countries most in need. Funding from these two sources—the Global Programme to Enhance Reproductive Health Commodity Security and the Maternal Health Thematic Fund—complements UNFPA core resources and other funding mechanisms and is used to implement and scale up interventions to promote the health of women and their babies. The resulting initiatives are designed to be integrated into national health plans and achieve a strategic and catalytic response. This is accomplished by harnessing strong technical expertise, encouraging innovation, and fostering South-South cooperation.

The Maternal Health Thematic Fund, known as the MHTF, was launched in 2008 and currently includes UNFPA's flagship programme in midwifery and the Campaign to End Fistula. It is supporting activities in 43 countries. The fund's business plan, which was grounded in the latest scientific evidence and programme results, identified maternal death and disability as an entry point for programmes to advance universal access to reproductive health. Accordingly, the thematic fund focuses on four key areas of intervention: family planning;[1] emergency obstetric and newborn care; human resources for health, particularly through the Midwifery Programme; and the prevention and treatment of obstetric fistula.

Results achieved since the fund's inception

In less than four years, and with cumulative expenditures of approximately $60 million, the Maternal Health Thematic Fund has achieved impressive results. Perhaps most noteworthy is the fact that maternal health is now high on the global and national agendas. The thematic fund has contributed to this rise through extensive communication and advocacy efforts, joint efforts by the H4+ group,[2] and support to the United Nations Secretary-General's 'Every Woman Every Child' initiative.

As a direct result of the thematic fund:

- **By the end 2011, needs assessments in emergency obstetric and newborn care had been carried out or were under way in 24 countries.** These assessments help map the current level of care and provide the evidence needed for planning, advocacy and resource mobilization to scale up emergency services in every district.

[1] On family planning, the MHTF works in synergy with the Global Programme to Enhance Reproductive Health Commodity Security in the areas of policy, service delivery and demand-generation.

[2] The World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the World Bank, and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

- **Work is under way in 30 countries to strengthen and scale up the midwifery workforce,** a critical element in filling the human resource gap in maternal health. The first-ever *State of the World's Midwifery* report was launched in 2011, providing data on the status of midwifery in 58 countries.

- **Improvements in maternal and newborn health services are ongoing in 30 priority countries.**[3] These efforts are already contributing to increased coverage of lifesaving care, and early reports suggest a decreasing number of maternal deaths in some of the health facilities receiving support.

- **Systems for real-time surveillance of maternal death and response are being promoted and instituted,** with the goal of fostering greater technical and political accountability towards the elimination of maternal mortality.

- **More than 27,000 women have received surgical fistula repairs since 2003.** This is a direct result of UNFPA's work as a leader and major contributing partner to the Campaign to End Fistula. The campaign is now in high gear in more than 50 countries, with the participation of 64 agencies and organizations at the global level and hundreds of other organizations partnering with UNFPA fistula programmes in countries around the world.

Highlights of 2011

The Maternal Health Thematic Fund completed its third full year of operations in 2011. Below are highlights of accomplishments during that year in selected areas of maternal health:

Fostering a policy and political environment conducive to maternal health

- In collaboration with WHO, UNICEF and the World Bank, UNFPA supported governments of priority countries in making over 27 new commitments to implement the UN Secretary-General's Global Strategy for Women's and Children's Health. UNFPA continues to provide direct support to the Office of the Secretary-General on various aspects of the strategy.

- In September 2011, a high-level consultation resulted in soon-to-be-completed national assessments of the midwifery workforce in eight countries representing over 60 per cent of the world's maternal deaths (Afghanistan, Bangladesh, Ethiopia, Democratic Republic of the Congo, India, Mozambique, Nigeria and the United Republic of Tanzania).

- Support to the United Nations' Commission on the Status of Women resulted in the adoption of a resolution on "eliminating maternal mortality and morbidity through the empowerment of women" at its 56th session.

- Continued support to the African Union's Campaign to Accelerate Maternal Mortality Reduction in Africa resulted in renewed financial and political commitments to maternal health in 10 African countries in 2011. Over 35 countries have signed on to date.

- Maternal health—and UNFPA's role in supporting it—was front and centre in global development discussions as a result of aggressive media and communications work throughout the year, which reached more than 500 million people. UNFPA's communications team worked closely with a growing number of partners in generating wide media coverage for events including the launch of the *State of the World's Midwifery* report, the one-year anniversary of the 'Every Woman Every Child' initiative, and the '7 Billion Actions' campaign. The team also worked with artists and musicians from around the world to make motherhood safer.

- Reproductive health coordination teams are now active in 30 countries, up from 26 countries in 2010. Twenty-two countries have developed a communication and advocacy strategy for reproductive health.

Increasing access to emergency obstetric and newborn care

- Ten countries[4] carried out national assessments of emergency obstetric and newborn care (EmONC) in 2011, bringing the total to 24 since the inception of the MHTF. The assessments, carried out in collaboration with UNICEF and Columbia

[3] The term 'priority countries' refers to countries with high maternal mortality ratios and a high unmet need for contraceptives.
[4] Benin, Burkina Faso, Burundi, Chad, Ghana, Guyana, Lao People's Democratic Republic, Liberia, Malawi and Niger.

UNFPA Executive Director, Dr. Babatunde Osotimehin, visits with fistula patients in the Dhaka Medical College Hospital in Bangladesh.

Photo by Anwar Majumder

University's Averting Maternal Death and Disability Program, provide reliable baselines and data that can be used for scaling up services and mobilizing funds. They have also helped to identify key issues in improving the quality of care, including the use of inexpensive lifesaving drugs. EmONC assessments are in the planning stages in another 10 countries, bringing the total to date to 34.

- Based on the assessments described above, many countries are strengthening their EmONC services, district by district. Cambodia, for example, has instituted routine monitoring of the upgrading of EmONC services, and Madagascar is building the capacity of EmONC health workers. Continued strengthening of EmONC services in Guyana has led to a drop in maternal deaths.

Ensuring skilled attendance at every delivery: The Midwifery Programme

- The thematic fund has supported 30 countries in strengthening midwifery policies and regulations, advancing midwifery education, and building associations of midwives. These efforts were carried out in close partnership with the International Confederation of Midwives (ICM).

- Twenty-two midwifery advisers are now deployed to build capacity in 19 countries.

- Global standards for midwifery education and regulation, developed by the ICM, have been finalized and distributed worldwide. Countries are being supported in aligning their programmes with these new standards.

- Thirteen countries identified gaps in their midwifery capacities and policies. This brings the number of gap analyses and needs assessments completed to date to 27.

- Some 150 midwifery schools were equipped with textbooks, clinical training models, equipment and supplies. In most priority countries, the skills of midwifery tutors have been upgraded, ensuring that they can better help others save lives, provide advice in the area of family planning, and prevent mother-to-child transmission of HIV.

- New Bachelor of Science in Midwifery programmes were launched in Ghana and Sudan. Meanwhile, the annual number of midwifery graduates worldwide continues to grow: Cambodia saw an increase from 370 to 616 from 2010 to 2011; the number of graduates in Zambia grew from 300 in 2009 to 505 in 2011.

- Likewise, massive increases in midwifery enrolment have been seen in some countries: Burundi has seen a doubling of midwifery students every year since 2009; in Ethiopia, 1,634 students enrolled in an accelerated midwifery programme in 2011 alone.

- Since the Midwifery Programme's inception, new national and subnational midwifery associations have been launched in Afghanistan, Bangladesh, Burkina Faso, Burundi, Ethiopia, Guyana, Nepal, Rwanda, South Sudan and Zambia.

- South-South cooperation continues to grow. A highlight in 2011 was an agreement by Uganda with the world's youngest nation, South Sudan, to train that country's midwifery workforce until it can develop its own training capacity. A $19.5 million proposal to strengthen midwifery in South Sudan was recently funded by the Canadian International Development Agency.

- A strategic partnership was developed with Jhpiego (John Hopkins Program for International Education in Gynecology and Obstetrics) to strengthen midwifery education and training at the country level.

- A partnership is also under way with the global technology giant Intel to develop e-learning material for pre-service and in-service training of midwives and to facilitate reporting of vital health information.

Spearheading the Campaign to End Fistula

- In 2011, UNFPA continued to lead and coordinate the partnership efforts of the Campaign to End Fistula. UNFPA also serves as the secretariat for the International Obstetric Fistula Working Group, including convening the annual meeting and maintaining the campaign website (www.endfistula.org).

- The first Global Fistula Care Map was launched, highlighting 150 treatment facilities in 40 countries. This comprehensive online resource was compiled in collaboration with Direct Relief International, the Fistula Foundation and other Campaign to End Fistula partners.

- The *Competency-Based Fistula Training Manual* for fistula surgeons (in English and French) has been finalized in partnership with the International Federation of Gynecology and Obstetrics.

- A landmark fistula study is ongoing in three countries (Bangladesh, Ethiopia and Niger). The study, carried out in partnership with the Johns Hopkins University Bloomberg School of Public Health, is examining post-operative prognosis, improvement in the quality of life, social reintegration and the rehabilitation of fistula patients after surgical repair in treatment centres.

A woman in Niger with her newborn.
Photo by Tomas van Houtryve

- With direct support from UNFPA, over 7,000 women and girls in 42 countries received surgical fistula treatment and care in 2011.

- Fourteen countries to date have established national task forces for fistula to improve coordination and communication among partners and stakeholders; new coordination mechanisms were created in Nigeria, Mozambique and Sierra Leone in 2011.

- A regional consultation on obstetric fistula surveillance was held in Nepal in September 2011, organized by UNFPA's Asia and the Pacific Regional Office. During the meeting, nine countries shared experiences on prevention, treatment and rehabilitation practices and policies. Countries including Cambodia and the Lao People's Democratic Republic are now developing fistula programmes.

- Congressional staff in the United States were briefed on obstetric fistula in May 2011 to encourage US support for fistula programming around the world.

- South-South exchanges involving two dozen countries were carried out, including the training of Pakistani fistula surgeons in Kenya.

Promoting quality maternity care and maternal death surveillance and response

- The Maternal Health Thematic Fund is advocating use of the partograph, a paper graph used to measure progress during labour. This simple device alerts health workers to the need to refer a patient for Caesarian section, thus averting potential maternal and newborn deaths and the development of obstetric fistulas.

- Maternal death surveillance and response was adopted by partners as a framework for the elimination of maternal mortality—a major contribution of UNFPA towards accountability in maternal mortality reduction. In addition, six priority countries (Benin, Burundi, Ethiopia, Ghana, Madagascar and Malawi) are moving towards institutionalization of maternal death audits to improve the quality of care.

Supporting family planning

- Given the broad scope of its sister fund (the Global Programme to Enhance Reproductive Health Commodity Security), the MHTF's support to family planning was limited to specific target areas. These included advocacy, technical guidance, neglected areas such as post-partum family planning, and interventions to generate demand, including community mobilization through drama and radio 'entertainment education'.

- During the year, the thematic fund was an active contributor to two major family planning conferences, in Ouagadougou and Dakar. The communication team helped shape the messages of the conferences and was instrumental in media outreach, positioning UNFPA as a leader in family planning.

Mobilizing communities for maternal health

- In 2011, the thematic fund continued to mobilize support for maternal health by working with civil society and religious leaders, and with communities themselves, to generate demand. Key areas of action included the promotion of girls' education and the prevention of child marriage. In Burundi, sensitization workshops were held for religious and political leaders on the implications of family planning in that country's poverty reduction strategy and national health plan. In Senegal, mother-in-laws were mobilized as agents of social change. Grassroots efforts in Burkina Faso have led to greater accountability on the part of communities and measurable improvements in maternal health.

Spawning innovation

- Active engagement with the private sector has yielded a flagship partnership with Intel Corporation. As a result, information and communications technology, including high-speed Internet services, will be used to strengthen the training, reporting and caregiving services of midwives and other frontline health workers in Bangladesh and Ghana. Similarly, through a partnership with Frontline Medic Mobil, pilot projects were developed to improve real-time reporting of maternal deaths and stock-outs of commodities in Burkina Faso, Madagascar, Mali and Sierra Leone, through 'm-health'. In the United Republic of Tanzania, mobile banking technology is being used to facilitate money transfers to women with fistula, thereby enabling them to travel to treatment centres. In Bangladesh and Niger, mobile phones are enhancing communication, reporting and notification of new fistula cases by advocates working on behalf of fistula patients. UNFPA staff are lead experts on this subject.

Using monitoring and evaluation to foster a culture of learning

- A mid-term evaluation is under way of the Maternal Health Thematic Fund. It is being undertaken jointly with a UNFPA-wide thematic evaluation of maternal health. These evaluations, together with a mid-term evaluation of the Global Programme to Enhance Reproductive Health Commodity Security, will provide the basis for continual improvements in UNFPA-funded activities in support of maternal health.

Resources and management

Since the Campaign to End Fistula was integrated into the MHTF in 2009, donors have provided the majority of their funding to the Maternal Health Thematic Fund (which includes support for fistula prevention and treatment) and proportionally less to the trust fund for fistula.

The overall MHTF operating budget in 2011, for both maternal health and the Campaign to End Fistula, was $33.3 million, which included funds carried over from the fourth quarter of 2010. Approved allocations totalled $28.6 million, out of which $25.0 million was spent; this translates into a financial implementation rate of 87 per cent. These expenditures were distributed as follows: 85 per cent went to country and regional programmes, including expenditures by international non-governmental organizations and institutions supporting countries; 15 per cent was spent on global technical support.

An approximate distribution of MHTF resources by programming areas in 2011 was as follows: midwifery (27 per cent), fistula (20 per cent), emergency obstetric and newborn care (13 per cent), capacity-building of UNFPA country and regional offices (9 per cent), and other areas (31 per cent).

Challenges

Since publication by the United Nations in 2010 of *Trends in Maternal Mortality: 1990 to 2008*, new information suggests that progress in maternal health is continuing and may, in fact, be greater than previously thought. In Afghanistan, for example, recent estimates suggest that maternal mortality is 300 to 500 deaths per 100,000 live births. This is far better than the official ratio of 1,400 that was last reported in 2008. The latest official estimates (for 2010) show that major headway has been made in a number of priority countries in reducing maternal morbidity and mortality, the best evidence there is for continued support.

Monumental challenges remain. Countries in which maternal deaths and disabilities are highest are also the least developed and most difficult countries to work in. These include countries in conflict or post-conflict situations or facing other sorts of emergencies. Exacerbating the problem is a crisis in human resources for health, and for maternal health in particular. This is often accompanied by weak national capacity and leadership and insufficient capacity by the UNFPA country office. Both domestic and international financial resources are woefully inadequate to address Millennium Development Goal 5 and its two targets. This underscores the critical importance of the Maternal Health Thematic Fund's work and the need for a solid resource base on which this global support mechanism can depend.

Moving forward

We are now at a turning point. Well established foundations for maternal health need to be nurtured and sustained for accelerated progress in the coverage of proven, highly cost-effective interventions to avert maternal death and disability in the context of reproductive health. The Maternal Health Thematic Fund envisions a way forward based on four key actions:

1. Update the Maternal Health Thematic Fund Business Plan following planned evaluations and donor consultations.

2. Further strengthen the technical capacity of countries in greatest need.

3. Provide integrated technical and programmatic support using UNFPA's cluster approach.

4. Mobilize additional resources for sustained impact to meet the growing needs of the poorest countries.

The results described throughout this report show what the Maternal Health Thematic Fund has been able to accomplish—with only modest resources—through a combination of state-of-the-art technical support and the strengthening of capacity. With continued efforts by countries, development partners and UNFPA, including the work of its thematic funds, it is likely that we can realize the vision contained in the MHTF Business Plan and together can "envisage, in the not too distant future, a world where maternal mortality has been eliminated."

INTRODUCTION

Improving health systems is one of the greatest challenges facing the developing world today. In fact, the severe lack of skilled health personnel could jeopardize recent advances in reducing maternal deaths. As this report will make clear, a skilled health worker, with midwifery competencies, can mean the difference between life and death for both a pregnant woman and her baby.

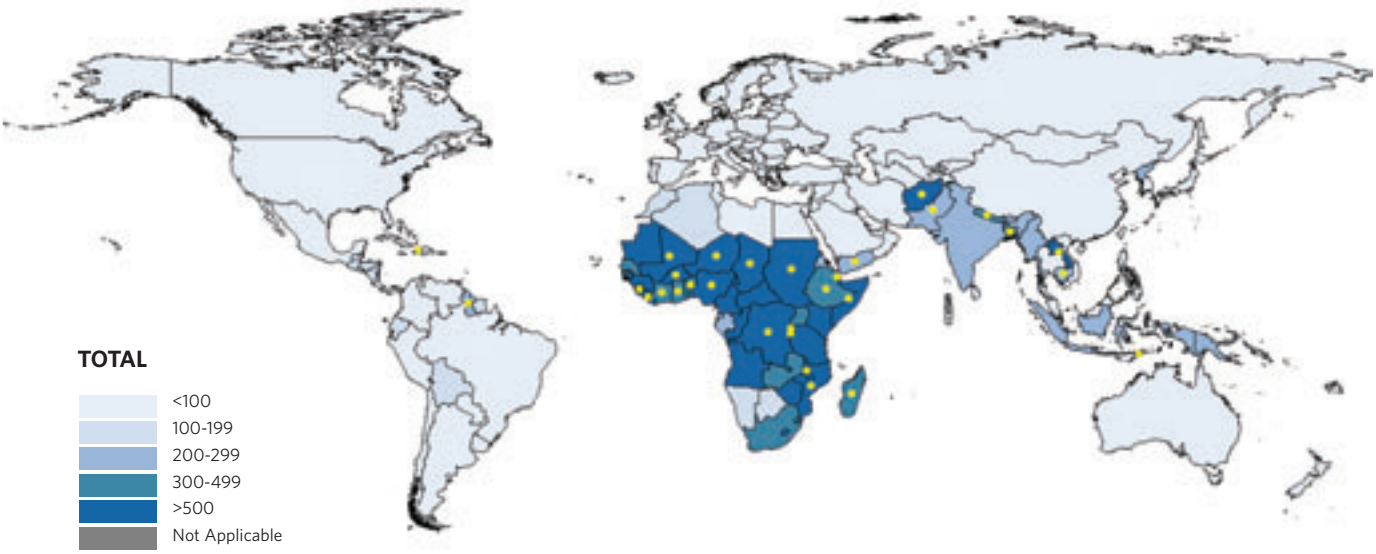
In a country such as Afghanistan, especially in remote areas, women often forego health services due to the fact that medical facilities may lack female health workers. To fill this gap, Saleha Hamnawzada, a midwife and mother of four, practised midwifery for 10 years out of mobile health clinics in hard-to-reach areas of Afghanistan. She could go where no male doctor could go. She also worked with husbands and families to allow pregnant women to give birth in a health facility. Currently, Ms. Hamnawzada is executive director of the Afghanistan Midwifery Association and has helped change the general perception of midwifery in Afghanistan: "Today a midwife who graduates from a community midwifery education programme is a woman well respected by the community," she says. "She can earn her own salary, and she represents a role model for the future generation. A midwife is not only saving women's and children's lives, she is also making a huge contribution to a more equal Afghanistan."

The UNFPA Maternal Health Thematic Fund champions an increase in the number of skilled health workers with midwifery competencies in countries where maternal mortality is high.

To accelerate reductions in maternal mortality and morbidity, UNFPA launched two thematic funds to provide enhanced support to countries most in need. Funding from these two sources—the Global Programme to Enhance Reproductive Health Commodity Security and the Maternal Health Thematic Fund—complements UNFPA core resources and other funding mechanisms and is used to implement and scale up interventions to promote the health of mothers and their babies. The resulting initiatives are designed to be integrated into national health plans and elicit a catalytic, innovative response. This is accomplished by harnessing strong technical expertise, tapping innovation, and fostering South-South cooperation among a select group of countries (Figure 1).

FIGURE 1

Geographic focus of the Maternal Health Thematic Fund (yellow dots indicate MHTF-supported countries and shading represents the maternal mortality ratio per 100,000 live births.[5])



In 2009, UNFPA integrated its Midwifery Programme and Campaign to End Fistula into the Maternal Health Thematic Fund. The reasons were twofold: to increase the MHTF's effectiveness and provide greater integration at the country level, and to reduce administrative and transaction costs. By incorporating these programmes under one umbrella, UNFPA not only facilitates greater efficiency, but encourages increased alignment at the country level. This *Maternal Health Thematic Fund Annual Report 2011* reflects outcomes and achievements of the fund's activities, including the Midwifery Programme and the Campaign to End Fistula.

Maternal health and reproductive health and rights

No woman should die giving life. This is the fundamental premise of efforts to improve maternal health, which seek to uphold women's reproductive rights through universal access to sexual and reproductive health—the essence of UNFPA's mandate and Millennium Development Goal 5 (MDG5).

Extensive research has shown that averting maternal death and disability can be accomplished most effectively when three conditions are met: 1) universal access to family planning, 2) the presence of a skilled health professional at every delivery, and 3) access to emergency obstetric and newborn care (EmONC). Should a pregnant woman with obstructed labour encounter delays in accessing emergency care—and should she survive— she may end up with an obstetric fistula, a severe complication that, if not addressed, could change her life forever. Treatment of obstetric fistula and social reintegration of fistula survivors is a fourth element of maternal health, which complements the above three and is now an essential component of UNFPA support in countries where the burden of maternal mortality is high. Accordingly, the Maternal Health Thematic Fund focuses on four key interventions:

1. Family planning
2. Emergency obstetric and newborn care
3. Human resources for health, particularly midwifery
4. Prevention and treatment of obstetric fistula.

[5] Countries currently receiving support from the Maternal Health Thematic Fund: Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Ethiopia, Ghana, Guyana, Haiti, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Mozambique, Namibia, Nepal, Niger, Nigeria, Pakistan, Rwanda, Sierra Leone, South Sudan, Sudan, Timor-Leste, Uganda, Yemen and Zambia. Ten additional countries receive support for obstetric fistula only: Cameroon, Central African Republic, Congo, Eritrea, Guinea, Guinea-Bissau, Kenya, Mauritania, Senegal and Somalia.

These interventions are part of a broader set of actions in the area of sexual and reproductive health that aim to strengthen health systems in general, stimulate demand, and address the broader social factors contributing to maternal death and disability. These include gender inequality, including low access to education—especially for girls; child marriage; and adolescent pregnancy. Figure 2 provides examples of specific interventions covered by the Maternal Health Thematic Fund using the 'Health System Building Block' approach of the World Health Organization (WHO).

One of the fundamental principles underlying the work of the Maternal Health Thematic Fund is that it fosters country-owned and country-led development that supports a national health plan. Therefore, the individual outputs and activities of the thematic fund are specific to each country: They are identified by governments through a consultative process involving key partners and stakeholders. Furthermore, to build synergies, the fund works in close coordination with the Global Programme to Enhance Reproductive Health Commodity Security, the Unified Budget Results and Accountability Framework of the Joint UN Programme on HIV/AIDS (UNAIDS), and the joint programme of UNFPA and the UN Children's Fund (UNICEF) on female genital mutilation/cutting. Another important principle is sustainability. Thus, every effort is made to invest in sustainable interventions for long-term impact, and to encourage national mechanisms for the development of maternal health.

Charting a course based on evidence and results

The first order of business in creating the Maternal Health Thematic Fund in 2008 was to develop a business plan[6] based on the latest scientific evidence. The goal was to bring more innovative approaches to this challenging area by drawing upon the most cost-effective interventions and on lessons from past programming in maternal health and other areas of reproductive health that have made more rapid progress.

FIGURE 2

How the MHTF fits into the WHO Health System of Building Blocks

Health System Building Blocks	MHTF support at the country level
Leadership and governance	Sexual and reproductive health policies and national commitments, equity focus in health plans, coordination mechanism, communication, partnerships
Service delivery	Needs assessments, community mobilization, scaling up of family planning, EmONC, midwifery, demand-generation, fistula services
Healthcare workforce	Special focus on midwifery, 'task-shifting', community health workers, obstetric fistula workforce (repair, social rehabilitation)
Medical products and technologies	Essential medicines and supplies, midwifery and EmONC anatomic models, fistula surgical instruments, etc.
Information	Health information system, maternal death audits, surveillance and response, monitoring, financing, innovation, costing, accountability, research
Financing	Universal access, reducing financial barriers, partnerships, domestic and international resource mobilization, and leveraging resources

The work of the MHTF is one of UNFPA's key contributions to H4+, a joint effort of WHO, UNICEF, UNFPA, the World Bank and UNAIDS that is supporting countries with the highest rates of maternal and newborn mortality. The MHTF supports and is also firmly aligned with the UN Secretary-General's Global Strategy for Women's and Children's Health ('Every Woman Every Child').

[6] United Nations Population Fund, 2008, *UNFPA Maternal Health Thematic Fund Business Plan 2008-2011*, New York, UNFPA. Available at: http://www.unfpa.org/public/publications/pid/3085

Selecting countries to receive support

The Maternal Health Thematic Fund selects countries to receive support based on recommendations from UNFPA regional offices and the following criteria:

- High maternal mortality (> 300 per 100,000 live births);
- Recommendations of the H4+ group, which identified 25 priority countries in 2008;
- Commitment of country teams (government and partners);
- Support by the Global Programme to Enhance Reproductive Health Commodity Security to foster synergistic action between the two thematic funds and accelerate coverage and impact.

Selected countries are invited to submit a proposal, which undergoes a process of peer-review and amendments, as required. Funding decisions are made in full agreement with governments as part of UNFPA support to the national reproductive health strategy. Once funding approval is granted and support begins, performance is closely monitored to ensure achievement of results. Since 2010, all MHTF-supported countries undergo a mid-year progress review to assess the implementation level of activities planned and funded by the thematic fund. Table 1 shows the number of countries supported by the Maternal Health Thematic Fund since its launch.

Research sheds new light on progress in maternal health

In May 2012, WHO, UNICEF, UNFPA and the World Bank published *Trends in Maternal Mortality: 1990 to 2010 WHO, UNICEF, UNFPA and The World Bank estimates.*[7] These estimates confirm that the annual number of maternal deaths has been reduced by half in 20 years, from 543,000 in 1990 to 287,000 in 2010. For example, from 1990 to 2010, the estimated maternal mortality decreased from 1,300 to 460 in Afghanistan, from 800 to 240 in Bangladesh, from 950 to 350 in Ethiopia and from 910 to 340 in Rwanda.

Furthermore, the overwhelming impact of family planning in saving women's lives and enhancing their reproductive rights is increasingly recognized. UNFPA's Global Programme to Enhance Reproductive Health Commodity Security plays a central role in this regard by helping to ensure a reliable supply of contraceptives at the country level. Readers are referred to the Global Programme to Enhance Reproductive Health Commodity Security 2011 Annual Report for a detailed discussion of progress in this area in many of the countries where maternal mortality is highest.

TABLE 1. Evolution of support to countries by the Maternal Health Thematic Fund, 2008-2011

	2008: Launch of the MHTF	2009: First full year of operations	2010: Second year of operations	2011: Third year of operations
Countries supported in maternal health overall	11	15	30	33*
Countries supported by the Midwifery Programme		15	22	30
Countries supported by the Campaign to End Fistula		25	42	43*
Total number of countries supported by the MHTF	**11**	**25**	**42**	**43***
Expenditures	**$ 1 million**	**$14 million**	**$21 million**	**$25 million**

* In 2011, Sudan became two countries, which is reflected in the figures in this table.

[7] Available at: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf

TABLE 2. Seven key outputs of the Maternal Health Thematic Fund

1.	An enhanced policy, political and social environment for maternal and newborn health and sexual and reproductive health
2.	Up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health, and emergency obstetric and newborn care
3.	National health plans focusing on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages to reproductive health and HIV to achieve the health MDGs
4.	National responses to the human resource crisis in maternal and newborn health, with a focus on planning and scaling up midwifery and other mid-level providers
5.	National equity-driven scale-up of family planning and emergency obstetric and newborn care services, maternal and newborn health commodity security, and obstetric fistula services
6.	Monitoring and results-based management of national efforts in support of maternal and newborn health
7.	Leveraging of additional resources for MDG5 from government and donors.

How this report is organized

At the core of the Maternal Health Thematic Fund Business Plan are seven country-level outputs, outlined in Table 2. Section One of this report tracks progress made in each of those seven areas, based on national results.

It should be noted that the MHTF Business Plan and its results framework will be revised in 2012 in light of an ongoing mid-term evaluation of the MHTF, an overall evaluation of UNFPA's work in maternal health, recent scientific evidence, and programmatic lessons from governments and development partners.

Section Two of this report encapsulates progress made in selected areas of maternal health, including midwifery and fistula. Section Three presents financial data. And Section Four provides a summary of challenges at the national and global levels; it also highlights key actions to propel maternal health forward.

SECTION ONE

Progress as measured by seven key outputs

The following section details progress made towards seven key outputs developed by the Maternal Health Thematic Fund in its 2008–2011 Business Plan.

OUTPUT 1

An enhanced policy, political and social environment for maternal and newborn health and for sexual and reproductive health

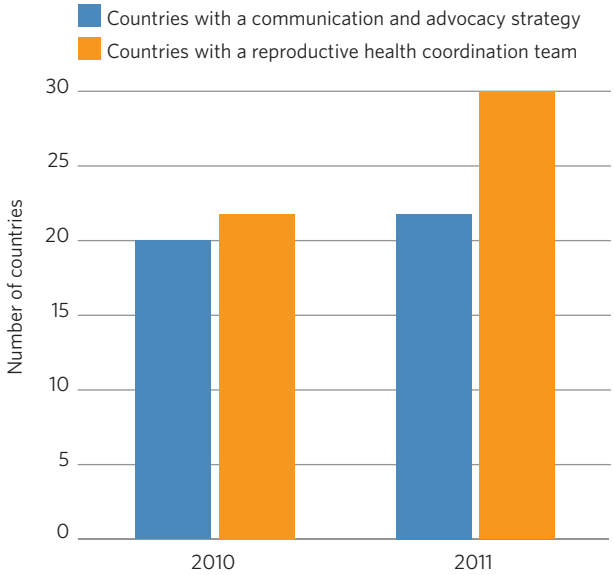
Political commitment, coupled with a supportive legal, social and economic environment, is critical to achieving the MDGs, particularly MDG5. Continuous and effective communication, advocacy and policy dialogue to increase political mobilization at the global, regional and national levels is essential to improving maternal and newborn health and to mainstreaming sexual and reproductive health.

Two indicators are used to track progress in these areas: the presence or absence of 1) a comprehensive communication and advocacy strategy for sexual and reproductive health, and 2) a reproductive health coordination team, led by the ministry of health with UNFPA and other multilateral, bilateral and civil society partners.

Figure 3 illustrates progress in Output 1 among 33 countries considered priorities by the MHTF. It shows an increase from 2010 to 2011 in the number of countries that have a comprehensive communication and advocacy strategy for sexual and reproductive health and a reproductive health coordination team.

FIGURE 3

Number of countries with a national communication and advocacy strategy for sexual and reproductive health and a reproductive health coordination team, out of 33 MHTF-supported countries



A nurse with her essential life-saving equipment in Mozambique.

Photo by Benedicte Desrus/Sipa Press/UNFPA

OUTPUT 2

Support for up-to-date needs assessments for the sexual and reproductive health package, with a particular focus on family planning, human resources for maternal and newborn health, and emergency obstetric and newborn care

Countries with high maternal mortality are typically those with the weakest health information. One of the first major tasks in accelerating improvements in maternal and newborn health is to assess the safety of births carried out in each of a country's health facilities. In addition, the severity of problems must be measured and a baseline established against which future progress can be assessed. Emergency obstetric and newborn care (EmONC) needs assessments are surveys of national health facilities that serve three main functions. They:

- Establish a programme baseline in every district;
- Serve as an advocacy tool to promote maternal and newborn health and to improve the coverage and quality of services;
- Help set priorities based on need and available human and financial resources, thereby guiding the scaling up of maternal health services, district by district (district micro-planning).

A key priority for the Maternal Health Thematic Fund has been helping countries carry out such needs assessments. By the end of 2011, 24 countries had completed or were engaged in developing an EmONC needs assessment with direct support from the MHTF. [8] Ten additional countries are planning such assessments in 2012 (Figure 4).

Among the countries with high maternal mortality ratios, the following still require support in the area of emergency obstetric and newborn care: Kenya, Nigeria, Pakistan, Rwanda, Uganda and Zambia. All high maternal mortality countries should have an up-to-date EmONC needs assessment until they can capture real-time data on maternal mortality through their national health management information system.[9] A global report on the state of emergency obstetric and newborn care is in the planning stages.

By the end of 2011, the MHTF had supported 'gap analyses' on midwifery education, regulation and associations in 19 countries[10] (Figure 5). In Bangladesh, the results of a gap analysis were instrumental in persuading that country's government to establish a direct entry midwifery training curricula and to recruit midwives.

FIGURE 4

Cumulative number of MHTF-supported countries with needs assessments for emergency obstetric and newborn care (completed or in process)

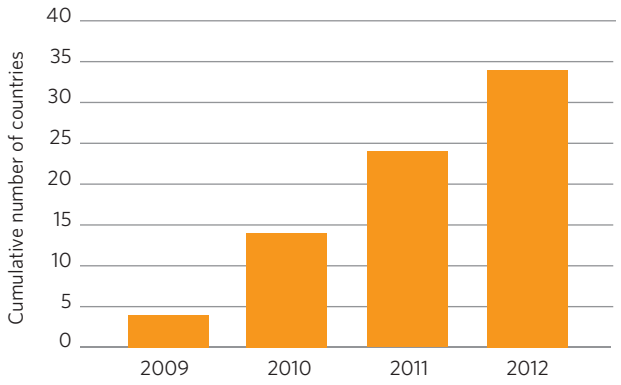
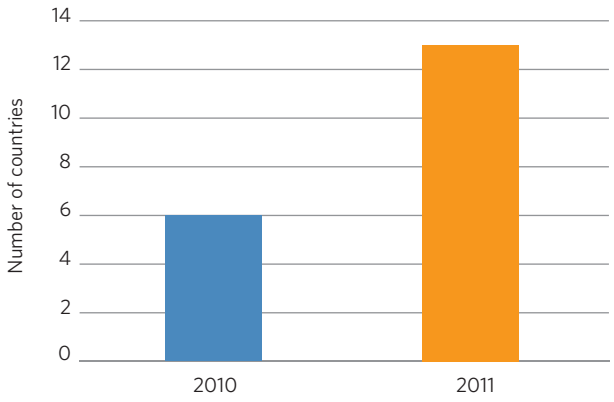


FIGURE 5

Number of MHTF-supported countries that have undertaken a gap analysis in midwifery



[8] Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Democratic Republic of the Congo (partial), Ethiopia, Ghana, Guinea, Guyana, Haiti, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Nepal, Niger, Nigeria, South Sudan, Togo.

[9] About 40 to 45 countries had high rates of maternal mortality at the time of this writing. New maternal mortality estimates were published in May 2012.

[10] Afghanistan, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Côte d'Ivoire, Djibouti, Ethiopia, Ghana, India, Madagascar, Nepal, Pakistan, South Sudan, Sudan, Timor-Leste, Uganda and Zambia.

OUTPUT 3

National health plans that focus on sexual and reproductive health, especially family planning and emergency obstetric and newborn care, with strong linkages between reproductive health and HIV to achieve the health MDGs

To ensure that sexual and reproductive health, including maternal and newborn health, is well positioned within national plans and strategies, the Maternal Health Thematic Fund continues to strengthen the human resource capacity of UNFPA country and regional offices. In 2011, it provided staffing support for 12 international experts in reproductive health/maternal and newborn health in the priority countries of Benin, Burundi, Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Guyana, Madagascar, Mali, Namibia and Nigeria. It also provided funding for 22 national midwifery advisers, three regional midwifery advisers, two regional reproductive health advisers for the Africa region and one country adviser for emergency obstetric and newborn care (Cambodia) (Figure 6). Similarly, the MHTF supported dedicated fistula focal points in five countries and in two regions, along with several part-time focal points, all of whom contributed to more effective programming and technical support for fistula repair, treatment and social rehabilitation. The drive to increase the number of dedicated full-time fistula focal points in regional and country offices was intensified during 2011. Significant increases in the number of full-time staff will be reflected in early 2012.

Figure 7 shows progress since 2010 in the development and costing of national plans for sexual and reproductive health (including family planning, midwifery, obstetric fistula, and emergency obstetric and newborn care), as reported by MHTF priority countries. Not only do more countries have a national plan in place, but all of these plans have been costed. This is critical to the planning and budgeting process, and to ensuring that resources are actually allocated for the implementation of plans.

FIGURE 7

Number of countries that have developed and costed national plans for sexual and reproductive health, out of 33 countries supported by the MHTF

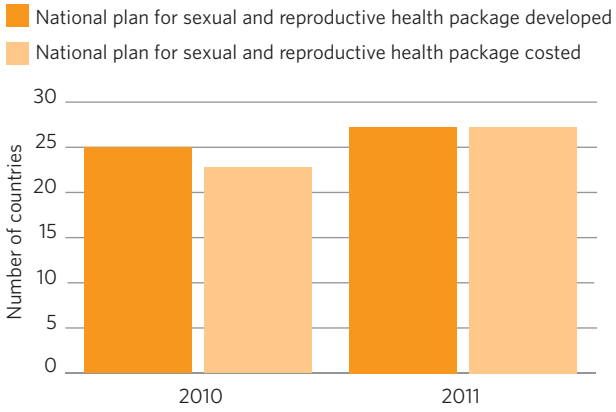
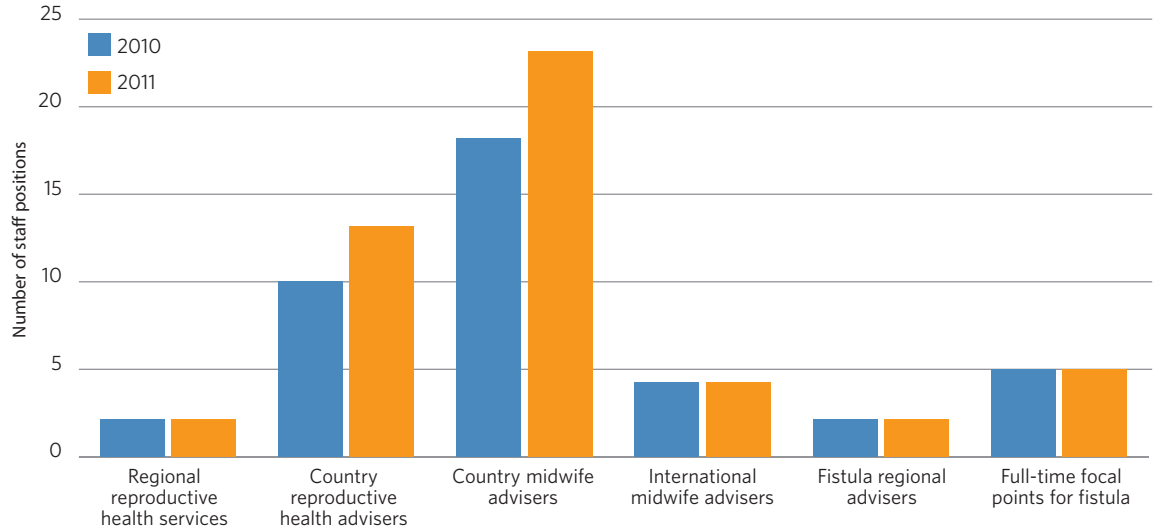


FIGURE 6

Number and type of staff positions in UNFPA country and regional offices supported by the MHTF



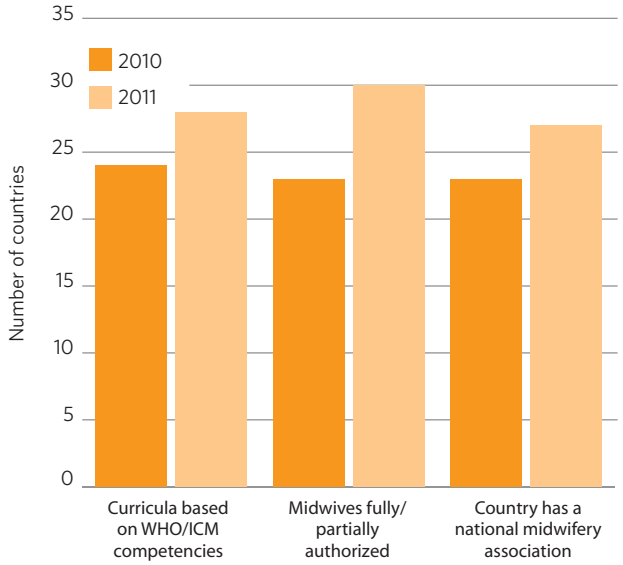
OUTPUT 4

Support the national response to the human resource crisis in maternal and newborn health, with a focus on planning and scaling up midwifery and other mid-level providers

Figure 8 shows progress in selected indicators related to midwifery education, regulation and associations in 30 countries[11] that received MHTF support for midwifery in 2011. Based on reporting from countries themselves, the data show that steady progress is being made in revising midwifery curricula to reflect competencies established by WHO and the International Confederation of Midwives (ICM), authorizing midwives to perform a core set of lifesaving interventions, and in forming national midwifery associations. Specific progress related to training institutions, the number of people entering or graduating from such institutions, and to midwifery regulation and association is outlined in Section Two of this report.

FIGURE 8

Progress towards midwifery education, regulation and associations in 30 MHTF-supported countries



OUTPUT 5

National equity-driven scale up of family planning and emergency obstetric and newborn care services, maternal and newborn health commodity security, and obstetric fistula services

This output was developed to reflect the level of maternal health interventions and their scale-up after situation analyses (including needs assessments related to emergency obstetric and newborn care, midwifery, fistula and family planning). Thus, the indicators in the MHTF Business Plan revolved around:

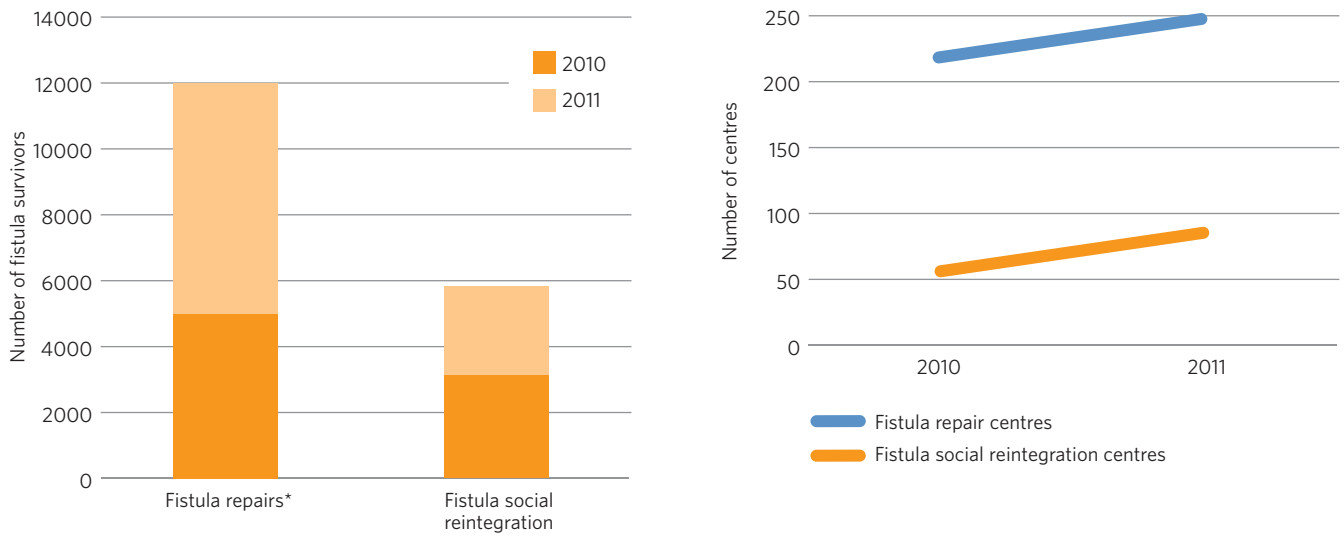
- Access and uptake of family planning (for example, service delivery points offering at least three modern methods of contraception, and the proportion of country commodity requests satisfied);
- Availability and met need for basic and comprehensive emergency obstetric and newborn care (EmONC survey indicators);
- Access to and uptake of fistula services (number of doctors trained in fistula repair, number of health professionals trained in fistula management, number of functioning treatment centres, numbers of women surgically treated and who have been offered social rehabilitation).

To avoid duplication, the reader is directed to relevant parts of Section Two (related to emergency obstetric and newborn care, midwifery, and support to family planning) to assess progress in these areas. In terms of fistula, the number of fistula repair and social rehabilitation centres continued to rise from 2010 to 2011, along with the number of women who have benefited from them (Figure 9). Still, services available fall far short of demand. More investment is required to address the backlog of women waiting for surgical repairs.

[11] Afghanistan, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Chad, Côte d'Ivoire, Democratic Republic of Congo, Djibouti, Ethiopia, Ghana, Guyana, Haiti, India, Lao People's Democratic Republic, Liberia, Madagascar, Malawi, Mali, Nepal, Nigeria, Pakistan, Rwanda, Sierra Leone, Uganda, South Sudan, Sudan, Timor-Leste and Zambia.

FIGURE 9

Number of fistula repair surgeries and social rehabilitation centres in 2010 and 2011



OUTPUT 6

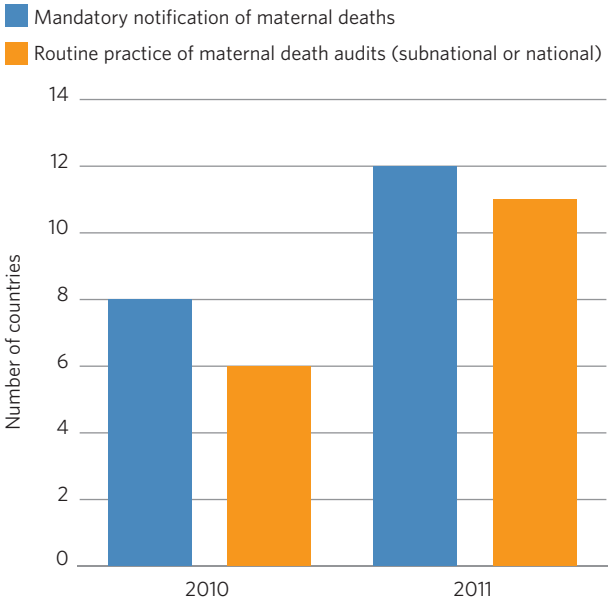
Monitoring and results-based management of national efforts in support of maternal and newborn health

Figure 10 shows progress in mandatory notification of maternal deaths and in the institutionalization of maternal death reviews in the first 15 countries[12] that received support from the Maternal Health Thematic Fund. These two indicators reflect accountability and commitment to quality maternity care, which is achieved through intensive and continuous advocacy and technical backstopping. The figure shows a 50 per cent rise from 2010 to 2011 in the number of countries reporting mandatory notification of maternal deaths; it shows an 83 per cent increase in the number of countries reporting that maternal death reviews are now a routine practice at the national or subnational levels.

More rapid progress in this area is expected with the establishment of the Commission on Information and Accountability for Women's and Children's Health, to which UNFPA contributed, and with the adoption by WHO and partners of the maternal death surveillance and response (MDSR) framework towards the elimination of maternal deaths.

FIGURE 10

Number of countries reporting mandatory notification of maternal deaths and institutionalization of maternal death reviews, in the first 15 countries[13] that received support from the MHTF



[12] This initial group of 15 countries includes Benin, Burkina Faso, Burundi, Cambodia, Côte d'Ivoire, Djibouti, Ethiopia, Ghana, Guyana, Haiti, Madagascar, Malawi, Sudan, Uganda and Zambia. With South Sudan now an independent country, the number of countries in this initial group totals 16.

[13] Now 16 countries, including Sudan and South Sudan.

OUTPUT 7

Support to countries in leveraging additional resources for MDG5 from governments and donors

Financial barriers are a major cause of bottlenecks in access to and uptake of healthcare in general and reproductive health in particular. To avoid such bottlenecks, sustained, long-term investments in healthcare at the country level are required. Typically, healthcare is funded by the government, the private sector and development partners, as well as by individuals and households (through out-of-pocket expenditures).

To measure government support for healthcare, and the financial burden that healthcare is placing on individual households, the indicator for Output 7 measures the share of the government budget devoted to health and per capita expenditures for health (Table 3). UNFPA, in partnership with other agencies (including the US Agency for International Development [USAID], WHO and the World Bank) is advocating for the monitoring of health financing indicators to provide an evidence base for advocacy and resource mobilization for reproductive health.

Among the UNFPA-supported countries in Africa, only Rwanda and Zambia have met the pledge made by African Union members to devote 15 per cent of their government expenditures to healthcare; some countries, including Chad and Nigeria, are still below 5 per cent. Twelve countries out of 21 have allocated more than 10 per cent of their budgets to healthcare, which is encouraging. However, out-of-pocket expenditures are still very high on average and, for the poorest families, can be catastrophic in their impact. UNFPA and its partners will continue to advocate for additional government resources for health. It is also focusing on developing the capacity of civil society and governments to track resource flows and demand accountability.

In line with the UN Secretary-General's Global Strategy for Women's and Children's Health and its Commission on Information and Accountability, UNFPA partners with the Netherlands Interdisciplinary Demographic Institute and other organizations to track resource flows in countries. It is also working to develop the capacity of national institutions to conduct national health accounts (and, in particular, reproductive health sub-accounts).

TABLE 3. Percentage of government expenditures devoted to health and per capita expenditures for health, by country*

Countries by region	Share of government expenditure for health (%)	Percent out-of-pocket expenditures
Africa		
Benin	9.6	46.8
Burkina Faso	13.5	36.2
Burundi	8.1	37.9
Chad	3.27	72.6
Côte d'Ivoire	5.1	77.5
Democratic Republic of the Congo	9.1	35.9
Ethiopia	13.5	37.2
Ghana	12.1	26.9
Liberia	11.1	35.2
Madagascar	14.7	27.1
Malawi	14.2	11.1
Mali	10.6	53.2
Mozambique	12.2	13.6
Namibia	–	–
Niger	11.1	41.3
Nigeria	4.4	59.2
Rwanda	20.1	22.1
Sierra Leone	6.4	79.4
South Sudan	–	–
Uganda	12.1	49.8
Zambia	15.6	26.5
Arab States		
Djibouti	14.2	34.4
Somalia	–	–
Sudan	9.8	67.1
Yemen	4.3	74.8
Asia and the Pacific		
Afghanistan	1.59	83.0
Bangladesh	7.36	64.1
Cambodia	10.5	40.4
Lao People's Democratic Republic	5.9	51.2
Timor-Leste	–	–
Nepal	7.4	64.1
Pakistan	3.6	50.5
Latin America and the Caribbean		
Haiti	4.5	NA
Guyana	15	NA

* **Source:** WHO, UNICEF. *Countdown to 2015. Maternal, Newborn & Child Survival. Building a future for women and children.* Geneva: World Health Organization, 2012.

UNFPA has contributed to the development of national health accounts in Burkina Faso, Ethiopia and Malawi; in 2011, accounts for Cameroon, Kenya and Nigeria got under way and discussions on the issue were undertaken with officials in Mali, Uganda and the United Republic of Tanzania. That said, the skill set needed to conduct such exercises are scarce, even when drawing from a global pool of experts. Consequently, progress has been slower than the UNFPA would have liked.

UNFPA has also been catalytic in improving the sustainability of reproductive health services in priority countries by leveraging resources at the country level. For example, the UNFPA county office in Madagascar raised an additional $100,000 to complement the funds provided by MHTF for 'm-health'[14] (for monitoring of maternal deaths and of stocks of health commodities). In Mozambique, the UNFPA office was instrumental in mobilizing $20 million from the Canadian International Development Agency through a joint proposal[15] in support of a national plan to achieve MDGs 4 and 5. In Rwanda, the UNFPA office led an advocacy effort for family planning with parliamentarians that resulted in significant additional resources to health and, more specifically, to reproductive health. Bangladesh has secured extra resources for fistula services from the Islamic Development Bank; Côte d'Ivoire did the same, by mobilizing resources from the Republic of Korea. Under the leadership of UNFPA, Cameroon launched the Campaign to Accelerate Maternal Mortality Reduction in Africa and mobilized $1.4 million for a large-scale training programme for providers of emergency obstetric and newborn care in disadvantaged regions. Similarly, in Niger, the launching of the campaign, which was organized by UNFPA, resulted in the mobilization of $4 million in special resources for maternal health from the Government of Spain and the European Commission. In Ethiopia, UNFPA is receiving continued funding from Sweden for midwifery and fistula-related services. Recently, based on the work supported by the MHTF, UNFPA's South Sudan country office received confirmation of a five-year, $19.5 million grant from the Canadian International Development Agency for strengthening that country's midwifery services.

[14] The term 'm-health' refers to mobile health and the use of mobile telecommunications and multimedia technologies within an increasingly mobile and wireless healthcare delivery system.

[15] Involving UNFPA, USAID, PSI (Population Services International), Pathfinder and WHO.

SECTION TWO

Progress in ten areas of maternal health

The following section provides additional details on progress in ten areas that have the greatest impact on reducing maternal morbidity and mortality: the policy and political environment for maternal health, emergency obstetric and newborn care, the Midwifery Programme, the Campaign to End Fistula, quality maternity care, maternal mortality surveillance and response, support for family planning, mobilizing communities for maternal health, innovation, and evaluation.

1. Policy and political environment

With UNFPA support, major inroads were made in 2011 to create a positive political and policy environment for reproductive health—at the global, regional and country levels.

Global action spurs new national commitments

In collaboration with UNICEF, WHO, UNAIDS and the World Bank, UNFPA supported national actions to advance the UN Secretary-General's Global Strategy for Women's and Children's Health. Over 27 new commitments were made by individual countries in 2011, ranging from expanding the midwifery workforce (Benin, Cambodia and Sierra Leone), to increasing budget allocations for maternal and newborn health (Burkina Faso, Senegal), to eliminating mother-to-child transmission of HIV (Democratic Republic of the Congo).

In partnership with these same UN organizations and the International Women's Health Coalition, UNFPA organized a high-level meeting in New York in September of key actors in the field of human resources for health. The goal: to accelerate progress in human resource development for reproductive and newborn health, especially the training and deployment of community-level workers with skills in midwifery. Among the participants were heads of UN agencies, ministers of health and other senior health officials, the UN Secretary-General's MDG Advocacy Group, representatives of civil society, particularly women's organizations, and other health professionals. An important output of this consultation was a commitment from eight countries representing 60 per cent of maternal deaths worldwide to conduct national assessments of their midwifery workforce at the community level (Afghanistan, Bangladesh, Ethiopia, Democratic Republic of the Congo, India, Mozambique, Nigeria and the United Republic of Tanzania). These assessments, which cover the flow of midwives in and out of the workforce, along with their recruitment, deployment and retention, are currently under way. They will not only serve as a basis for improving policy, but will enhance the management of this critical workforce, ensuring adequate competencies at the community level.

In 2012, the UN Economic and Social Council's Commission on the Status of Women adopted a resolution on "eliminating maternal mortality and morbidity through the empowerment of women" at its 56th session. This landmark resolution was drafted and nurtured by UNFPA and provides countries with a human rights framework towards the elimination of maternal mortality as a public health burden.

A midwife and a mother with her newborn baby in the Edna Aden Maternity Hospital in Hargeisa, Somalia.

Photo by Roar Sorensen

Communication efforts continue to move the maternal health agenda forward

Communication is a central strategy of the Maternal Health Thematic Fund for fostering an enabling political and policy environment, and 2011 was an exceptional year in that regard. UNFPA documentaries and video news releases on maternal health, midwifery and fistula reached more than 500 million viewers and political decision makers that year, through broadcasters including the BBC, CNN and Al-Jazeera. Strategic screenings were also organized in several donor and developing countries where the burden of maternal mortality is high.

Continued partnerships in the area of communication helped UNFPA reach new groups and steer the maternal health agenda in the right direction throughout the year. This included work with artists and musicians across the globe who contributed sound tracks and videos to help mobilize resources for maternal health; partnerships with non-governmental organizations (NGOs), in initiatives such as 'Every Woman Every Child', the Partnership for Maternal, Newborn & Child Health and Women Deliver; partnerships with private sector companies, such as Johnson & Johnson, Virgin Unite and SAP in an initiative called 7 Billion Actions; and with governments, including the United Kingdom's Department for International Development (DFID) and USAID.

In late 2011, the world's largest-ever conference on family planning took place in Dakar, Senegal. UNFPA was there, highlighting the need for an integrated approach to health, the connections between maternal mortality and women's access to family planning, and the importance of addressing young people's needs. The communication team worked with conference organizers on messaging and on attracting media attention. It also made sure that the linkages between family planning and reproductive health were articulated in both the programme and in the strong media coverage that resulted.

At the regional level, the launch of the Campaign to Accelerate Maternal Mortality Reduction in Africa continues to elevate reproductive health and reproductive rights at the international and regional level and bolster policies and programmes at the national level. Thirty-six countries in Africa have now successfully launched the campaign, including 10 countries in 2011. In the Asia and Pacific region, the Asian Forum of Parliamentarians on Population and Development garnered new commitments to dramatically reduce maternal, newborn and child mortality, as part of the global Strategy for Women's and Children's Health and with support from UNAIDS, UNFPA, UNICEF, the World Bank and WHO. These commitments should lead to more effective measures to reduce mortality, increase demand for family planning and improve access to and uptake of emergency obstetric and newborn care.

At the country level, UNFPA developed an evidence-informed communication project designed to link communication with results. The project has now been launched in Benin, Burkina Faso, Ethiopia, Niger, Nigeria Malawi, Mali, Senegal and Sierra Leone. It focuses on the use of local data and real-life stories to influence policy-making and resource mobilization. Several short stories have been produced and are being used for communication efforts and to enliven policy discussions (for examples, see: http://www.youtube.com/watch?v=sDLshI5RCuo&feature=youtube_gdata_player, http://www.youtube.com/watch?v=nSfEj33nqrY&feature=youtube_gdata_player).

2. Emergency obstetric and newborn care

One of the three pillars of maternal mortality and morbidity reduction is emergency obstetric and newborn care (EmONC). The Maternal Health Thematic Fund has adopted a three-pronged approach to support priority countries in this crucial area: a global technical partnership; development of norms and guidance documents; and direct support at the country level through needs assessments, training, the upgrading of facilities and monitoring the scale up of such facilities.

Needs assessments help countries improve emergency care

The importance of EmONC needs assessments for planning and advocacy purposes is outlined in Output 2. Progress is measured by the production and dissemination of survey findings, the use of survey results for planning the upgrading of EmONC services at the district level, and for addressing training and supervision capacity-

development activities. In undertaking such assessments, UNFPA has nurtured an alliance with Columbia University's Averting Maternal Death and Disability Program, known as AMDD. It is also working in partnership with UNICEF in the areas of advocacy, financial and technical support, and needs assessments in priority countries. A handbook for monitoring emergency obstetric and newborn care has been jointly published in English and French in cooperation with WHO, UNICEF, the World Bank and AMDD.

Table 4 and Figure 11 show the results of recently conducted EmONC needs assessments in eight countries (Benin, Burkina Faso, Burundi, Côte d'Ivoire, Ghana, Guyana, Liberia and Niger). On all six indicators surveyed, the results are alarming and clearly point to the reasons why these countries, with the exception of Guyana, are experiencing very high maternal mortality.

Less than 10 per cent of the countries surveyed have the required number of health facilities needed to perform comprehensive emergency and newborn care. In fact, two countries (Burundi and Liberia) have more facilities than the national requirement, which shows the disconnect between national systems and what is actually needed to save the lives of women and newborns.

Direct obstetric case fatality rates (defined as the proportion of women with major direct obstetric complications who die in an emergency obstetric and newborn care facility) should not exceed 1 per cent. However, as Figure 11 shows, all of the eight countries surveyed, with the exception of Burundi and Guyana, had rates that were 1.5 to 2 times higher, on average—an indication of serious lapses in the quality of care. It also demonstrates the importance of implementing maternal death reviews. The neonatal mortality rate (death during the first 28 days of life per 1,000 live births) is particularly high in Burkina Faso, Burundi and Niger. This suggests problems in facility-based care during labour and childbirth. In most countries, the rates for Caesarian sections remain below the minimum recommended of 5 per cent of all deliveries.

Another key observation: When women are referred to hospital because of complications, lifesaving medicines and blood transfusions are not always available. In fact, in some countries (Burkina Faso, Burundi and Côte d'Ivoire) the availability of magnesium sulfate (a very inexpensive, lifesaving medicine used to manage eclampsia and pre-eclampsia) is an alarming 6 per cent to 20 per cent. These baselines data are very useful for planning upgrades of EmONC services, conducting evidence-based advocacy and instilling accountability.

FIGURE 11

Direct obstetric case fatality rate for eight MHTF-supported countries

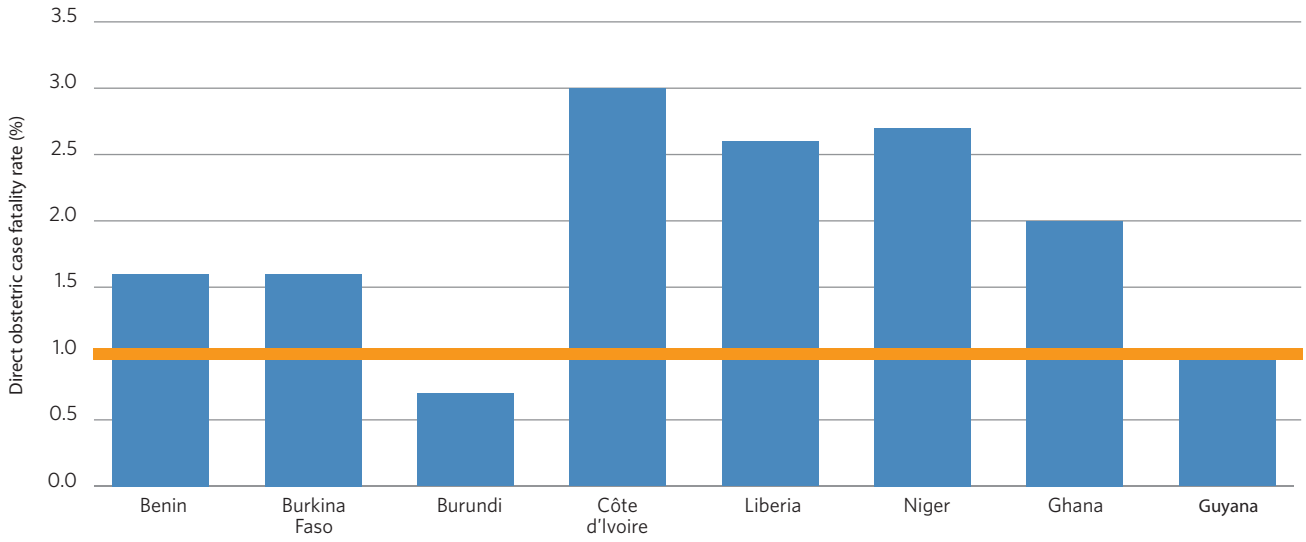


TABLE 4. Sample indicators for emergency obstetric and newborn care in MHTF-supported countries *(continued on next page)*

EmONC indicators	Benin	Burkina Faso	Burundi	Côte d'Ivoire
Total number of facilities assessed*	417	1,982	276	1,419
Availability of basic EmONC facilities**	7 facilities (Minimum acceptable level: 71)	4 facilities (Minimum acceptable level: 122)	5 facilities (Minimum acceptable level: 66)	17 facilities (Minimum acceptable level: 248)
Availability of comprehensive EmONC facilities	22 facilities (Minimum acceptable level: 18)	21 facilities (Minimum acceptable level: 31)	17 facilities (Minimum acceptable level: 16)	11 facilities (Minimum acceptable level: 50)
Geographic distribution: Proportion of subnational areas with the required number of EmONC facilities (minimum acceptable level, according to international standards, is five, including one comprehensive facility for every 500,000 population)	Not only do none of the country's regions meet the minimum acceptable level, but 6 out of 12 have a lower geographic distribution of facilities than they did in 2003	3 out of 13 regions meet the minimum acceptable level	Only one province out of 17 meets the minimum acceptable level and 3 provinces have no basic EmONC facilities	No region out of 19 meets the minimum acceptable level for either basic or comprehensive EmONC facilities
Proportion of all births in EmONC facilities	17.1%	4.5%	2.2% in basic EmONC facilities; 10.5% in comprehensive EmONC facilities	2.1%
Met need for EmONC†	30.2%	12.3%	13.1%	5%
Direct obstetric case fatality rate: The case fatality rate among women with direct obstetric complications in emergency obstetric care facilities (should not exceed 1%)	1.6%	1.6%	0.7%	3%
Neonatal mortality rate: Intrapartum and very early neonatal death	19 per 1,000 live births	70 per 1,000 live births	94 per 1,000 live births	15 per 1,000 live births (in basic EmONC facilities) and 29 per 1,000 live births (in comprehensive EmONC facilities)
Caesarian sections as a proportion of all births	4.6% (normal range: 5%-15%)	1.5% (normal range: 5%-15%)	4.3% (normal range: 5%-15%)	1.9% (normal range: 5%-15%)

Some key outputs of the EmONC needs assessments include:

- Systems for maternal death surveillance and response (Cambodia, Burkina Faso);
- Mandatory notification of maternal death and inclusion of maternal death reviews as indicators in the national health information system (Burundi);
- A 'task-shifting' diploma for EmONC (Ethiopia), meaning that general practitioners are trained to carry out certain lifesaving procedures normally in the domain of surgeons and obstetricians;
- A training-of-trainers course for the upgrading of competencies in the midwifery workforce (Madagascar);
- The scaling up of maternal death audits (Madagascar, Malawi, Ethiopia, Haiti);
- Subnational fact sheets for district micro-planning (all countries);
- Resource mobilization for maternal and newborn health (all countries).

TABLE 4. Sample indicators for emergency obstetric and newborn care in MHTF-supported countries *(continued)*

EmONC indicators	Niger	Liberia	Ghana	Guyana
Total number of facilities assessed*	503	304	1159	43
Availability of basic EmONC facilities**	15 facilities (Minimum acceptable level: 152)	1 facility (Minimum acceptable level: 37)	13 facilities (Minimum acceptable level: 194)	1 facility (Minimum acceptable level: 8)
Availability of comprehensive EmONC	29 facilities (Minimum acceptable level: 30)	9 facilities (Minimum acceptable level: 7)	76 facilities (Minimum acceptable level: 121)	0 facilities (Minimum acceptable level: 2)
Geographic distribution: Proportion of subnational areas with the required number of EmONC facilities (minimum acceptable level, according to international standards, is five EmONC facilities, including one comprehensive facility for every 500,000 population)	5 out of 9 provinces meet the recommended minimum	6 out of 15 districts meet the recommended minimum	0 out of 10 districts meet the recommended minimum	0 out of 2 regions meet the recommended minimum
Proportion of all births in EmONC facilities	23.2%	9.9%	21%	87%††
Met need for EmONC†	19.6%	5.5%	17%	14%
Direct obstetric case fatality rate: The case fatality rate among women with direct obstetric complications in emergency obstetric care facilities (should not exceed 1%)	2.7%	2.6%	2%	1%
Neonatal mortality rate: Intrapartum and very early neonatal death	79 per 1,000 live births	24 per 1,000 live births	26 per 1,000 live births	22 per 1,000 live births
Caesarian sections as a proportion of all births	1.4% (normal range 5%-15%)	9.5% (normal range 5%-15%)	7% (normal range 5%-15%)	13% (normal range 5%-15%)

* Partially functioning facilities are not included. Figures are based on signal function performance in the preceding three months (signal functions are key medical interventions used to treat the direct obstetric complications that cause the vast majority of maternal deaths around the globe).

** Minimum acceptable level of basic EmONC facilities includes only basic facilities.

† Number of women treated for direct obstetric complications at emergency care facilities over a defined period divided by the expected number of women who would have major obstetric complications.

†† Institutional delivery, including in EmONC facilities.

3. The Midwifery Programme

Launched in 2008 by UNFPA and the International Confederation of Midwives (ICM), the Midwifery Programme is currently helping 30 countries strengthen their midwifery programmes and policies. Twenty-two midwifery advisers are working with relevant stakeholders in 19 countries to improve the quality of midwifery training and services, policies and associations. These advisers are supported technically by ICM regional advisers. They are strategically guided by the UNFPA programme coordinator, the MHTF team and technical advisers for sexual and reproductive health based in countries, regionally and at UNFPA headquarters.

The goal of the midwifery programme is to improve skilled attendance at all births in low-resource countries by developing the foundations of a sustainable midwifery workforce. To achieve this, the programme supports and guides national efforts by:

- Building capacities in ICM/WHO competency-based midwifery training and education;
- Developing strong regulatory mechanisms to promote the quality of midwifery services and protect the public;
- Strengthening and establishing midwifery associations;

- Conducting proactive advocacy with governments and stakeholders to encourage investment in quality midwifery services to save the lives of women and their newborns (thereby contributing to the achievement of MDGs 4, 5 and 6).

The main highlight of 2011 was the launch of the first-ever *State of the World's Midwifery* report—an ambitious collaborative effort that was led and coordinated by UNFPA. In addition, a partnership with Jhpiego (the Johns Hopkins Program for International Education in Gynecology and Obstetrics) was formalized through the signing, in 2011, of a Memorandum of Understanding to strengthen midwifery education and training at the country level and to bolster the capacity of UNFPA in this area. Another important new partnership was formulated in 2011—with the private sector global technology giant Intel. The objective is to strengthen access to and the quality of training of midwives using information and communications technology, including high-speed Internet. More details on these are other achievements are highlighted in the sections below.

Global highlights and results

National commitment to midwifery increases

UNFPA's leadership and support to countries have resulted in concrete commitments by more than 25 countries to scale up and better manage their midwifery workforce, in line with the UN Secretary-General's Global Strategy for Women's and Children's Health (see: www.everywomaneverychild.org). Table 5 provides examples of some of these commitments.

The first State of the World's Midwifery *report launched*

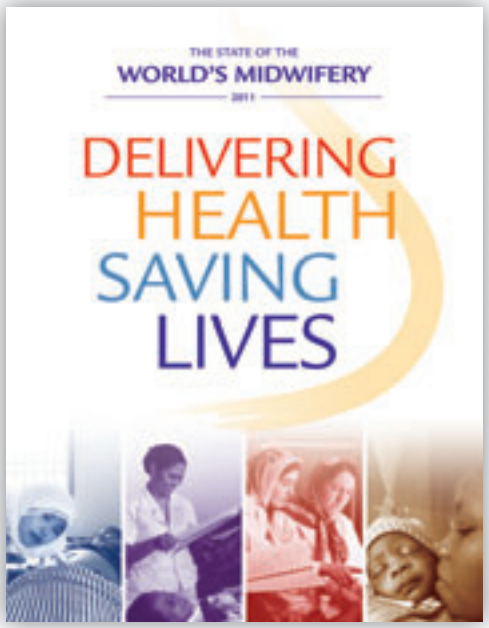
The collaborative efforts of some 30 partners under the leadership of UNFPA resulted in the launch of the first *State of the World's Midwifery* report in June 2011 in Durban, South Africa. The report responds to a joint Call to Action issued at the Global Midwifery Symposium in 2010. It reviews the state of midwifery in 58 low-resource countries representing 91 per cent of the global burden of maternal mortality and 82 per cent of newborn mortality. It also provides fresh data and analysis, identifies common challenges and highlights promising approaches to strengthen midwifery services around the world. The findings reiterate the shortage and uneven distribution of midwives, the lack of standardization in education, and an urgent need for strengthening the regulatory and policy framework for midwifery. The report is being used as an advocacy and strategic planning toolkit with the goal of enhancing national commitment to midwifery.

Since the global launch of the report, more than two dozen countries have carried out national launches. Several new national and global commitments towards midwifery have emerged, in alignment with the UN Secretary-General's Every Woman Every Child initiative.

TABLE 5. Selected midwifery-related commitments to women's and children's health by country

Country	Commitment
Afghanistan	Double its midwifery workforce from 2,400 to 4,556
Bangladesh	Train an additional 3,000 midwives, staffing all 427 sub-district health centres to provide round-the-clock midwifery services
Burundi	Increase the number of midwives from 39 in 2010 to 250, and the number of training schools for midwives from 1 in 2011 to 4 in 2015; increase the percentage of births attended by a skilled birth attendant from 60 per cent in 2010 to 85 per cent in 2015
Chad	Strengthen human resources for health by training 40 midwives a year for the next four years, including creating a school of midwifery and constructing a national referral hospital for women and children with 250 beds
Ethiopia	Quadruple the number of midwives from 2,050 to 8,635
Lao People's Democratic Republic	Produce 1,500 new midwives by 2015
Rwanda	Train five times more midwives (increasing the ratio from 1/100,000 to 1/20,000)
South Sudan	Train and employ 4,600 midwives by 2015

The report is available in English, French and Spanish and can be downloaded at: http://unfpa.org/sowmy/report/home.html



International Day of the Midwife celebrated globally

Celebrating the International Day of the Midwife (5 May) has now become a key feature of the UNFPA/ICM programme calendar. In 2011, it was once again celebrated with the slogan: 'The World Needs Midwives Now More Than Ever'. The purpose was to raise awareness of midwifery and bring greater visibility to the role midwives play in promoting health and saving the lives of women and their babies. Around 25,000 midwives took part in events spanning 88 countries on or around 5 May.

Events included discussions, debates, workshops, walks and activities involving free healthcare, cervical and breast cancer screenings, family planning workshops and blood donation camps. Health ministers, midwifery leaders and senior government officials, along with other relevant UN and civil society partners, participated in the celebrations.

A media and information pack prepared by ICM and UNFPA provided valuable media resources including fact sheets, posters and a slide show made from award-winning photographs collected through a photo competition organized for the *State of the World's Midwifery* report. UNFPA country offices reported wide media coverage on television, radio and web news that helped secure renewed commitments from policy makers.

ICM Congress encourages sharing among midwives worldwide

UNFPA was a key partner of the ICM's 29th Triennial Congress in June. This global event, in Durban, South Africa, brought together 3,000 midwives from over 100 countries to advocate for the critical role midwives play in reducing maternal and newborn mortality, and to share best practices, experiences and knowledge. The Congress' scientific programme featured over 400 workshops and concurrent sessions, while daily plenary and partner panels brought together top-level policy makers and maternal and child health experts.

A UNFPA collaboration with the White Ribbon Alliance resulted in the production of a documentary titled 'Stories of Midwives', which profiled their inspiring work.

Communications and media used for strategic ends

The selection of Robin Lim as the CNN Hero of the Year has helped draw worldwide attention to midwifery and the importance of investing in human resources for health. Lim is an American midwife who has helped thousands of poor Indonesian women have a healthy pregnancy and delivery.

The media strategy carried out for the launch of the *State of the World's Midwifery* report resulted in heightened visibility for midwifery issues globally and increased political commitment. Highlights from the report were featured on global wire services including the Associated Press, Agence France Presse, IRIN News and Reuters. In all, over 300 websites and other major global news media, including the *Washington Post, The Guardian*, Voice of America, Radio France International, BBC Radio, Al Jazeera and CNN carried coverage of the report. In addition, UNTV's UN in Action produced features on midwifery in Gaza, Bangladesh, South Sudan, South Africa, Nigeria, Lao People's Democratic Republic and Uzbekistan. Midwifery visuals were made available to 560 broadcasters worldwide through UNifeed. Wide coverage was also reported from several African television stations, including Nigerian TV, DRTV and MNTV in the Congo.

Several UNFPA country offices, including those in Bangladesh, Lao People's Democratic Republic, South Sudan, Uganda and Uzbekistan also produced films about midwifery in 2011.

Global competencies and standards for midwives endorsed

Following endorsement at the ICM Congress in June, midwifery is now one of the few health professions to have established global competencies and standards for education, regulation and association. Taken together, these competencies and standards provide a professional framework that can be used by midwifery advisers, educators, regulators, association leaders and governments to plan, strengthen and raise the standard of midwifery practice in their countries. The standards can be found at: http://www.internationalmidwives.org/Whatwedo/Policyandpractice/ICMGlobalStandardsCompetenciesandTools/tabid/911/Default.aspx.

Knowledge-sharing widens

An internal UNFPA knowledge management platform on midwifery (community of practice) was launched in November 2011. The main purpose was to create a repository for all available information on midwifery and promote knowledge-sharing among countries. UNFPA staff were trained through a webinar for keeping the asset updated.

Regional highlights

Capacity of midwife advisers and national stakeholders expands

The *ICM Global Standards, Competencies, and Tools* was disseminated at two regional workshops to UNFPA advisers and to stakeholders from 18 African and seven Asian countries. The workshops took place in Accra, Ghana in September and in New Delhi, India in November. The pre-service education standards developed by Jhpiego, based on ICM competencies, were also disseminated to all countries and through webinars conducted for the training of UNFPA staff.

Asian workshop promotes harmonization of midwifery education

The Asia Regional Education Harmonization Workshop, held in New Delhi in December 2011, resulted in consensus-building around the need to harmonize midwifery education. Participants overwhelmingly endorsed the need to set up a regional resource centre on midwifery that would help promote South-South exchanges in the region. The workshop also saw the launch of a joint statement supporting the strengthening of midwifery by development partners in India.

Regional partnerships continue to grow

Partnerships with regional institutions such as the East Central and Southern College of Nursing, Pan American Health Organization, West African College of Nursing, West Africa Health Organization and the Federation of Associations of Midwives were further strengthened, with the strategic objective of combining efforts to promote the profession of midwifery. Of particular concern is harmonizing education and regulations in the regions in an integrated manner.

Box 1. Ensuring safe motherhood in the world's youngest nation

In South Sudan, the world's youngest nation, UNFPA has deployed 18 international UN Volunteer midwives across teaching, state and county hospitals in all of the country's 10 states. A mid-term review carried out in October 2011 revealed the tremendous impact of this project, which has resulted in over 7,000 safe deliveries in hospitals and facilities. Volunteer midwives also provided treatment in more than 2,000 complicated pregnancy cases and provided more than 10,000 women with clinic-based antenatal care. Additionally, 47 community midwives have completed an 18-month programme at the South Kajo Keji and Maridi National Health Training Institutes.

A Memorandum of Understanding to further South-South cooperation between Uganda and South Sudan was also signed. The agreement has enabled 16 midwifery students to commence studies in Uganda. The students have signed a binding agreement with the Ministry of Health in South Sudan to serve in their country for at least five years after completing a two-and-a-half year course of study.

Country highlights

Midwifery schools strengthened and equipped

The Maternal Health Thematic Fund continued to strengthen and equip 150 midwifery schools across developing regions by providing anatomical training models, medical equipment, textbooks and essential supplies. Ghana now has two new schools. In Benin, the midwifery training school re-opened and, in Cameroon, four new midwifery schools have been established. In Sudan, three midwifery schools were rehabilitated in 2011, and in-service training was provided to 60 village midwives and 30 midwifery technicians. In Bangladesh, eight institutions were assessed for conducting midwifery trainings. Of these, four nursing training institutes have been identified and equipped to conduct six-month post-basic training on midwifery. Sierra Leone, a new programme country, saw the rehabilitation and strengthening of two of its midwifery schools.

In Ethiopia, the MHTF equipped 18 training schools; the total number of midwifery training institutions has increased from five in 2000 to 30 in 2011; currently, 11 universities offer a Bachelor of Science degree in midwifery.

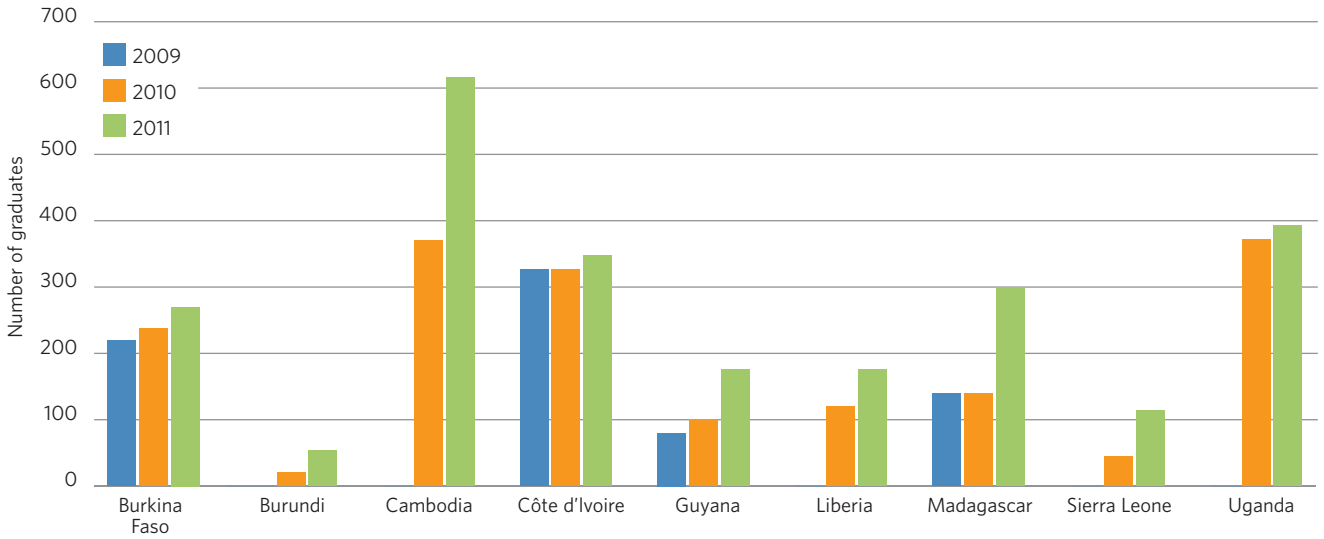
Skills of current and future midwives sharpened

With support from the MHTF, the number of midwifery students and graduates has grown (Figure 12). In Burundi, the number of midwifery students has increased fivefold, from 20 in 2009 to 100 in 2011. In Ethiopia, 1,634 students were enrolled in an accelerated midwifery programme that will place midwives in rural areas; students' practical skills are being monitored through the use of 5,000 logbooks. The programme is also supporting scholarships for students to complete their midwifery studies in countries including South Sudan, Uganda and Zambia.

The programme has also helped enhance the skills of midwifery tutors. In Bangladesh, 53 new midwifery tutors were trained in 2011. Midwives in countries such as Benin, Burkina Faso, Burundi, Côte d'Ivoire, Djibouti, Haiti, Sudan, Uganda, Zambia and Zimbabwe received additional training in advanced clinical skills and lifesaving techniques. In Mozambique, UNFPA supported the ISCISA Training Centre, which will fine-tune the skills of 248 nurses specializing in maternal and child health; training in Caesarian sections will also be provided to assistant medical officers in 11 provinces. In Uganda, 54 midwifery tutors and clinical instructors from 10 nursing and midwifery schools and hospitals were oriented to new policies and guidelines related to midwifery practice, including family planning, partography, HIV/AIDS and gender issues.

FIGURE 12

Trends in the annual number of midwifery graduates in selected MHTF-supported countries



Post-earthquake challenges remain for Haiti's Midwifery School, which has yet to be re-built. In the meantime, efforts are ongoing to strengthen emergency obstetric care skills of students; instructors are receiving further training in clinical skills and management of obstetric and newborn complications.

Training is also being provided to tutors to strengthen skills in teaching, clinical instruction, mentoring, supportive supervision and use of logbooks and protocols. For example, 41 tutors were trained in effective teaching skills in Ethiopia. In countries such as Burkina Faso, Ghana, Guyana and Uganda, senior and retired midwives have been trained in management and supervision techniques and are providing clinical training and supportive supervision to students. In Burkina Faso, over 500 students benefited from clinical training provided by retired midwives.

Midwifery curricula developed and updated

Countries reviewed their midwifery curriculum in light of the revised ICM competencies and education standards published in 2011 (Figure 13). Countries including Burundi, Cambodia, Chad, Ghana, Guyana, Nepal, Sudan, Uganda and Zambia revised their midwifery programmes and curriculums. In South Sudan, midwifery and nursing education standards have been developed. Haiti has developed an intermediate midwifery programme, which contains 80 per cent of the competencies directed by the ICM. Nepal is currently piloting a three-year Post-Basic Bachelor in Midwifery, based on ICM essential competencies and global midwifery standards. In Bangladesh, efforts are under way to develop a three-year direct entry Diploma Midwifery Programme. In Ghana, the new Bachelor of Science degree programme in midwifery commenced in October 2011. And Sudan has introduced a four-year Bachelor of Science Midwifery Programme, implemented by the Academy of Health Sciences.

In Sierra Leone, reproductive health commodity security training modules have been introduced in the teaching curricula of two midwifery schools. Increasingly, the UNFPA-ICM midwifery programme is integrating the areas of fistula and female genital mutilation/cutting within its training. For example, in Ethiopia, 41 midwives and nurses have been trained in prevention of fistula and identification of fistula clients.

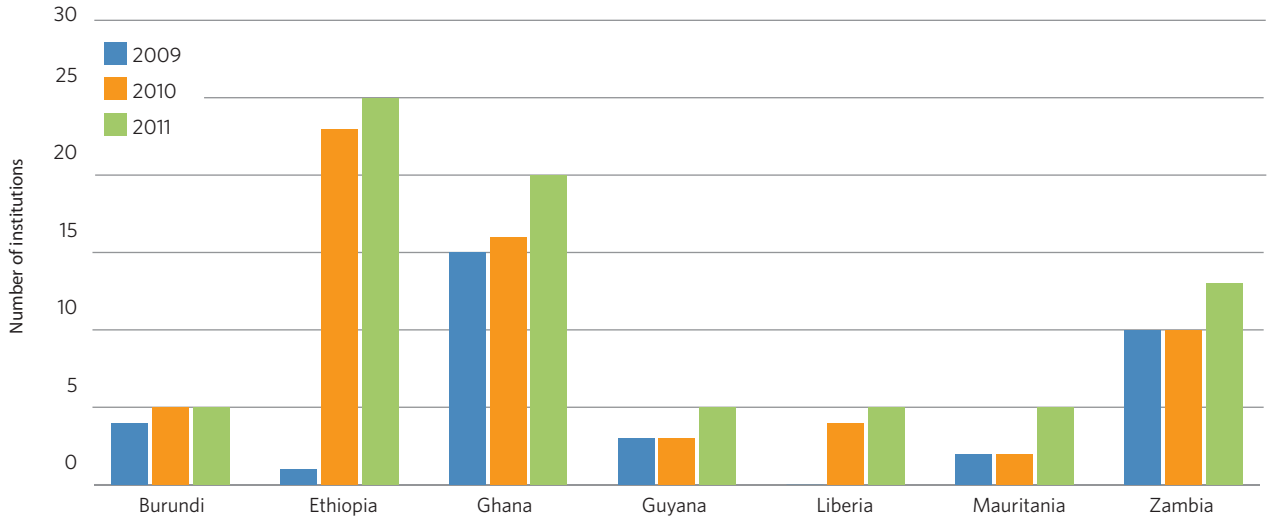
The year 2011 saw the finalization of the Standard Skills and Equipment List—a basic set of models, equipment, reference books and learning materials for regional and national reference by midwifery training institutions.

Regulation of midwifery profession tightened

Programme countries continue to advance in making midwifery a well-regulated profession with a clearly defined scope of practice and code of ethics. Both are critical to

FIGURE 13

Trends in the number of midwifery training institutions with updated curricula, in selected MHTF-supported countries



Midwives undergoing training in Afghanistan.
Photo by Bill Ryan

ensuring quality in service delivery and to protecting the public from unsafe practices. In this respect, the recently finalized ICM global regulation standards provide a benchmark and guidance to countries for developing their own country-specific standards.

Some examples: In Afghanistan, the National Policy and Strategy for Nursing and Midwifery Services has been developed and approved, and the first draft of the Midwifery Act has been prepared. The Bangladesh Nursing Council is developing a Midwifery Act that is awaiting approval by Parliament. The Cambodia Midwifery Council has strengthened internal rules and regulations for midwives and developed midwifery competency standards. It has also established offices in 17 provinces and three national hospitals and has four regional midwife councils. In Burkina Faso, midwives and other health professionals have received training on regulations. In Ghana, midwives participated in a workshop with Intel on the integration of information and communications technology into midwifery education and regulation. Midwifery regulations in Madagascar have been updated (based on earlier gaps identified) and are now included as annexes in the national Public Health Code.

In Uganda, the five-year strategic plan for the Nurses and Midwives Council and another for the Uganda Nurses and Midwives Union was developed in 2011. The Nurses & Midwifery Act was reviewed and gaps identified to inform the drafting of the Nursing & Midwifery Amendment Bill. In South Sudan, a Nursing and Midwifery Regulations and Planning Workshop organized in late 2011 brought together key midwifery and nursing educators and stakeholders from all 10 states. It resulted in a Call to Action to strengthen midwifery regulations in that country and a consensus on the establishment of an Interim Midwifery and Nursing Regulatory Task Force/Council.

Midwifery associations continue to receive support

The Maternal Health Thematic Fund continued to foster capacity-building of associations by strengthening their organizational, leadership and management skills. Many associations that have received such support have witnessed an increase in their membership and are implementing continuous education programmes.

Three new chapters of the Afghanistan Midwifery Association opened in 2011; the association is now represented in 32 out of 34 provinces. Its membership has also increased, to 2,600 in 2011. The association is spearheading the development of the Afghan Midwives and Nurses Council and has been instrumental in framing the national strategy on midwifery. It has been actively conducting mentorship programmes in some provinces and is developing a five-year strategic plan.

In Nepal, the national midwifery association conducted continuing education for 300 nurses and midwives in remote areas of the country. In Guyana, the midwifery association there actively provided supportive supervision and continuing in-service training for its members in over half the country's administrative regions; at the same time, it has seen a fourfold increase in its membership (300 of the 400 registered midwives in the country are now members). The association now has regional focal points in seven of the country's 10 administrative regions. As a result of these efforts, Guyanese midwives from all three of the country's midwifery schools achieved a 95 per cent success rate in State Midwifery Examinations.

The Ethiopian National Midwifery Association established two new regional branches, which brings the total to four. South Sudan established a Nursing and Midwifery task force and established one national and three new regional associations with 350 members. Zambia registered and formally launched a Midwives Association. Burundi's midwife association was recognized by the Ministry of Health. In Burkina Faso, an association of midwifery students specializing in obstetrics and gynaecology was formed. The associations in Burundi and Madagascar are now members of the ICM.

Midwifery associations have also increased their internal management capacity through development and revision of strategic and operational plans and development and maintenance of websites (Afghanistan, Bangladesh, Burkina Faso, Cambodia, Ghana, Ethiopia and Madagascar). In Cambodia, the midwifery association has designed and printed newsletters and membership cards, with distribution to all members. In Ghana, the association is using a consultant to help develop a five-year strategic plan and monitoring tool.

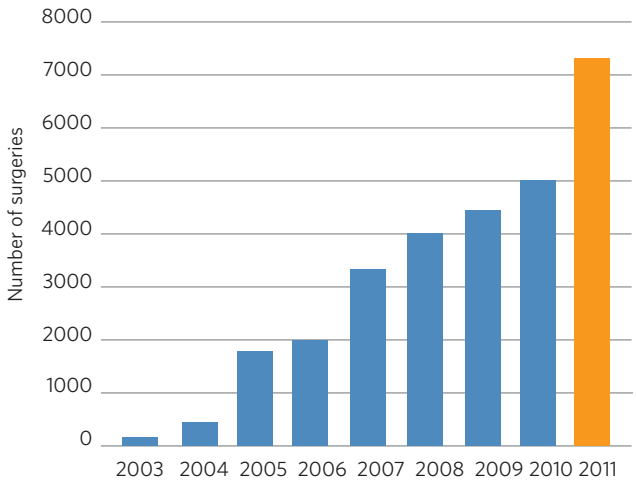
4. The Campaign to End Fistula

Obstetric fistula is a severe morbidity caused when a woman or girl suffers from prolonged obstructed labour without timely access to emergency obstetric care, typically a Caesarian section. The sustained pressure of the baby's head on the mother's pelvic bone damages her soft tissues, creating a hole—or fistula—between the vagina and the bladder and/or rectum. With skilled attendance at birth and timely access to emergency obstetric care, these injuries can be prevented. Yet, tragically, 50,000 to 100,000 new cases occur every year.

The global Campaign to End Fistula is an integral component of UNFPA's overall strategy to improve maternal health and reproductive health in general. By focusing on prevention, treatment and social reintegration, the campaign has helped women and girls from around the world overcome a debilitating condition that has left—and continues to leave— hundreds of thousands suffering in solitude and shame.

Since the campaign was launched in 2003, its presence has quadrupled in size—from 12 to more than 50 countries. Sixty-four partner agencies have joined the campaign (see Annex 1), with hundreds of other organizations partnering with UNFPA fistula programming in country offices. Over the last nine years, UNFPA has directly supported over 27,000 women and girls access fistula treatment and care (Figure 14). Today, more than 30 countries have integrated

FIGURE 14
UNFPA-supported fistula repair surgeries, 2003-2011



obstetric fistula into national plans and policies with an increasing number creating coordination mechanisms for fistula prevention, treatment and the reintegration of fistula survivors into society.

Key results in 2011

In 2011 alone, UNFPA:

- Supported fistula treatment for more than 7,000 women and girls in 42 countries;
- Facilitated training of more than 1,300 healthcare workers, including surgeons, nurses, midwives and community health workers;
- Provided social reintegration services to 2,700 women and girls surgically treated for obstetric fistula in 19 countries;
- Contributed to the establishment of 36 new functioning treatment centres and 25 new facilities offering social reintegration services;
- Fostered South-South cooperation among 24 countries.

In response to an external evaluation of the campaign in 2009, UNFPA developed an Orientation Note for obstetric fistula in 2011 that builds on previous work and provides a vision for the future. This includes a focus on national programming and sustainability; a gradual programmatic shift from fistula camps/campaigns to ongoing and integrated holistic services; and strategies to ensure the survival of the woman and child and to prevent a new fistula from occurring in the subsequent pregnancies of women who have received fistula surgery.

While this report focuses on UNFPA's role, partnerships continued to be the cornerstone of the campaign, and many partners have contributed enormously to advancing the cause:

- **EngenderHealth** has supported 23,000 fistula repair surgeries since 2001 through the Fistula Care project.
- **Equilibres & Populations,** a French NGO, brought focus to the issue of obstetric fistula in Cambodia and helped expand the campaign's presence in that country.
- **Fistula Foundation Nigeria** continued to lead the way in that country by providing support to incurable and inoperable cases.
- In 2011, **Healing Hands of Joy** scaled up their Safe Motherhood Ambassador project in Ethiopia, which resulted in the training of over 100 former fistula patients in basic maternal health skills, including reproductive health, hygiene, sanitation and prenatal care.

Selected global highlights and results

Fistula survivors help steer annual meeting

In October 2011, UNFPA organized the annual high-level meeting of the International Obstetric Fistula Working Group (IOFWG), in Maputo, Mozambique. The group is the main body promoting effective, collaborative partnerships to address all aspects of fistula. As a global coordination mechanism, the group facilitates partner dialogue and joint projects with five sub-working groups on: prevention and conservative management; advocacy and partnerships; treatment and training; data indicators and research; and social reintegration.

For the first time, two fistula survivors-turned-advocates were invited to sit alongside technical experts. The women, from Kenya, not only shared their work on the 'One by One Let's End Fistula' initiative, but actively participated in the working session and helped steer the fistula agenda forward. The meeting was attended by 46 members, including many new partners who focus primarily on advocacy and social reintegration.

First global fistula map launched

Throughout 2011, UNFPA worked closely with campaign partners Direct Relief International and Fistula Foundation to initiate the largest and most comprehensive map of available services for women living with obstetric fistula (see: www.globalfistulamap.org). The Global Fistula Care

Map (Figure 15), launched in early 2012, highlights over 150 health facilities providing fistula repair surgeries in 40 countries across sub-Saharan Africa, Asia and the Arab States. The map is a major step forward in understanding the landscape of worldwide treatment capacity and service gaps for obstetric fistula; it will also help streamline the allocation of resources. It will be expanded and continuously updated with information provided by experts and practitioners from around the globe about fistula repair and rehabilitation services.

Competency-based training manual for fistula surgeons developed

In close collaboration with the International Federation of Gynecology and Obstetrics (FIGO) and other partners, UNFPA helped finalize the Competency-Based Fistula Training Manual, a clinical training guide for fistula surgeons published in French and English. The purpose of the manual is to enable healthcare providers acquire the required knowledge, skills and professionalism to prevent fistula and provide holistic care to fistula patients. This includes medical, psychosocial and surgical care. UNFPA also began developing an associated document intended for campaign partners and ministries of health that provides broader strategic recommendations on the training of fistula surgeons. The document will be disseminated in 2012.

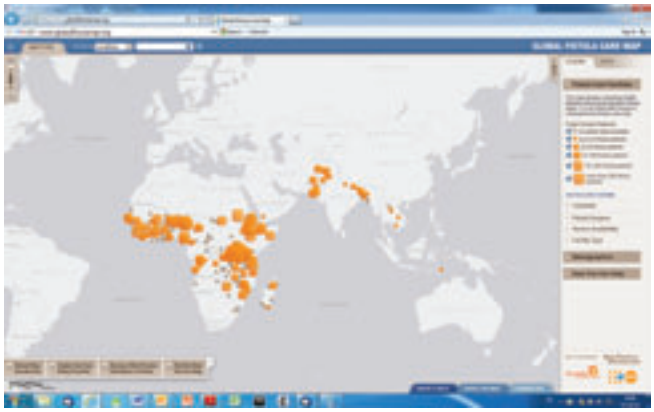
US Congress briefed on obstetric fistula

On 24 May 2011, UNFPA helped organize a congressional briefing in the United States—'End Fistula Forever'—with US Representative Carolyn Maloney and campaign partners EngenderHealth, Fistula Foundation, Human Rights Watch, International Women's Health Coalition and USAID. The briefing took place in Washington, DC, and aimed to educate members of Congress and their staff about fistula and to discuss the impact of US support for fistula programmes globally.

Communications and media are increasingly collaborative

With new and reinvigorated partnerships, one of the priorities for the Campaign to End Fistula is a more coordinated approach to the global response. This includes closer collaboration with partners in the area of communications and advocacy. Several joint communication and media initiatives were carried out in 2011, including the campaign newsletter, *Dispatch*, which showcased articles highlighting the achievements of fistula partners. Content was also more consistently shared for dissemination in other institutional platforms, increasing the reach of online content. The campaign saw a 5.3 per cent increase in media coverage in 2011, compared to 2010. Articles appeared in major global publications, including *Yo Dona*, a weekly magazine distributed as part of *El Mundo* newspaper (200,000 readers per week and 24 million web visitors per month), and *National Geographic* magazine (monthly circulation of 8.5 million copies). Both articles spotlighted UNFPA's work on fistula and its leadership of the Campaign to End Fistula. In coordination with UNFPA's 7 Billion Actions initiative, the campaign was also featured on PBS, in *Ms. Magazine, The Huffington Post* and other first-tier media.

FIGURE 15
Screenshot of the global fistula care map website



The work of global activists, national champions and campaign spokespersons helped to further support and highlight the work of the campaign. Natalie Imbruglia, Virgin Unite ambassador and spokesperson; Christy Turlington Burns, maternal health advocate and founder of Every Mother Counts; Sierra Leone First Lady Mrs. Sia Nyama Koroma; and fistula survivor Ms. Sarah Omega from Kenya are among the many advocates from around the world who helped mobilize support in 2011.

In June of that year, the campaign re-launched the End Fistula website to make it a more dynamic and interactive resource for partners seeking to share news, data and stories (www.endfistula.org).

Regional highlights and results

Asian fistula conference elicits positive response from Pakistan

Using the slogan 'Neglected No More—Dignity Restored', UNFPA's Asia and the Pacific Regional Office organized a two-day regional conference on fistula in Karachi, Pakistan in March 2011. The conference brought together 1,200 participants, including 10 international fistula surgeons from 14 countries. The event was an important milestone for highlighting the prevalence of fistula in Pakistan and led to a strong commitment by the Pakistan Ministry of Health to formulate a National Task Force for Fistula. UNFPA also helped organize 50 pre-conference workshops across the country to train gynaecologists, nurses, midwives and post-graduate students about obstetric fistula management and care. A three-day surgical camp was organized, which culminated in the successful surgical repairs of 19 previously unsuccessful cases.

Regional consultation facilitates South-South cooperation

The UNFPA Asia and the Pacific Regional Office organized a two-day regional consultation workshop on obstetric fistula surveillance in Kathmandu, Nepal in September 2011. The conference brought together 39 participants from nine countries. Because the level of experience and knowledge of obstetric fistula varies significantly within the region, the workshop was an important opportunity for critical knowledge-sharing on various prevention, treatment and rehabilitation practices and policies. Bangladesh and Nepal presented their model for obstetric fistula surveillance, an innovative new system that aims to address early identification of obstetric fistula cases and to improve data collection. The system is expected to be put in place in select districts in 2012 as a pilot project.

South-South cooperation continues to grow

South-South cooperation continued to grow throughout 2011 as more countries within and across regions shared expertise and resources. The Hamlin Fistula Center in Ethiopia treated five fistula patients from South Sudan and trained medical professionals from Zambia. Bangladesh provided training on fistula surgery, management and counselling to health professionals in Nepal and performed complicated fistula surgeries on six women in Timor-Leste. Three doctors from Pakistan travelled to Kenya to be trained on new techniques in post-surgical incontinence. Niger welcomed a team of doctors and surgeons from Haiti, who were trained in treating complex cases. In partnership with civil society and the USAID/Integrated Family Health Project, the UNFPA office in Benin hosted an African repair mission that included fistula surgeons from Chad and Mauritania and focused on teaching the latest techniques in fistula repair. A Senegalese doctor performed fistula surgeries in Chad, Gabon and Rwanda. And Lesotho sent fistula patients to South Africa for treatment.

Selected country highlights and results

National leadership on fistula expands

A key focus of the Campaign to End Fistula has been advocacy and political support for the integration of obstetric fistula into national policies and plans. This has resulted in new plans and policies in more than 30 countries since the campaign began in 2003. This year, UNFPA helped support the development and validation of obstetric fistula policies in Ghana, Guinea, Guinea-Bissau and Madagascar. In addition, Burkina Faso's Ministry of Health, supported by UNFPA, evaluated their 2004-2008 National Fight against Fistula programme and used their findings to develop a new programme. Sudan developed a National Obstetric Fistula Guidelines and Management Protocol, which will help streamline practices for all those involved in fistula care services.

To improve coordination and communication, 14 countries have established national task forces for fistula, including Sierra Leone, Mozambique and Nigeria in 2011. The task forces facilitate coordinated planning and interaction among partners working on fistula and ideally are led by ministries of health. Uganda's Technical Working Group served as a role model for other countries. Other coordination mechanisms recently developed include Nepal's Technical Working Group on Morbidities and Zambia's Safe Motherhood Technical Working Group, which includes obstetric fistula.

In Liberia, 2011 marked the beginning of a new process for ensuring a sustainable and nationally owned fistula programme. Liberia's Ministry of Health is fully engaged in the improvement of maternal health and, for the first time, management of obstetric fistula cases is being relocated

from privately owned facilities to public health institutions, with two new centres of excellence being developed in place of 11 existing facilities.

Fistula prevention efforts are spotlighted

In order to prevent future fistula cases, efforts have been made to improve the detection of obstructed labour and access to emergency obstetric care, typically a Caesarian section. In sub-Saharan Africa, only 23 per cent of births are attended by skilled health personnel, in comparison to an average of 65 per cent globally.[14] In response, UNFPA offices in 13 countries actively trained community midwives in obstetric fistula prevention and case identification in 2011. Togo has increased its responsiveness to reproductive health, including obstetric fistula, by adopting a new policy to subsidize 90 per cent of the total cost of Caesarian sections.

Maternity waiting homes are used to help bridge the gap in accessing obstetric care. These facilities are particularly important for any woman living in a remote region, especially repaired fistula cases, to ensure access to elective Caesarian sections. This will not only help prevent a recurrence of fistula, but will increase the odds that both mother and child will survive subsequent pregnancies. Eritrea used maternity waiting homes as part of a comprehensive package of essential obstetric services. As a result, an increase in the rate of skilled birth attendance was observed, including a 70 per cent increase in the number of deliveries in the Tio health facility between 2010 and 2011.

The Campaign to End Fistula also focused on addressing broader socio-cultural and gender norms by providing safe spaces for women to better understand what has happened to them. Liberia staged dramas acted by fistula survivors depicting the causes and consequences of obstetric fistula. Because young women are more likely to develop fistula, the Liberian programme specifically targeted high schools.

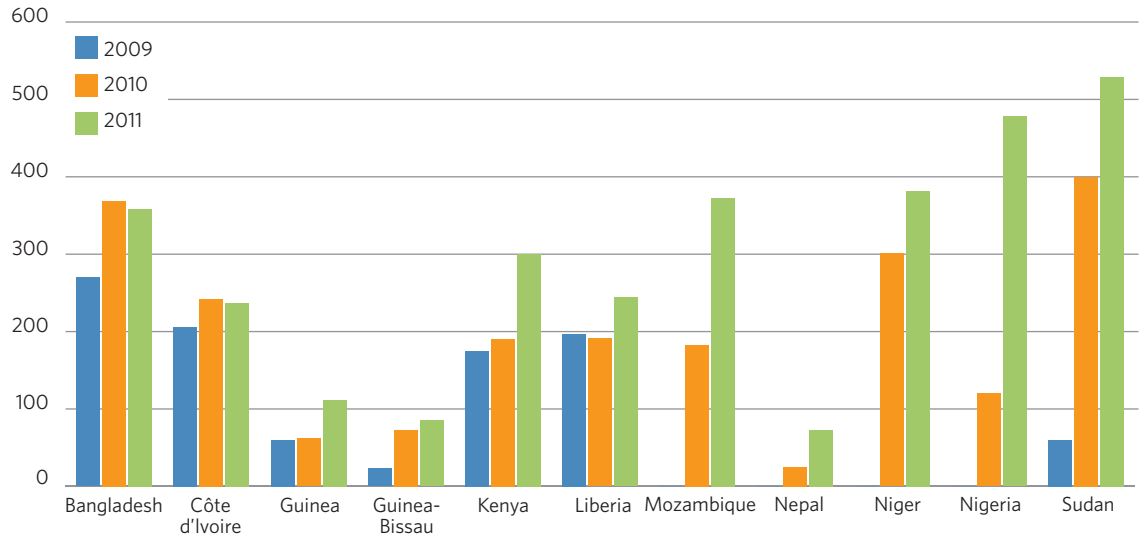
Fistula treatment is scaled up

UNFPA has set an ambitious goal of doubling the number of fistula repairs from 5,000 in 2010 to 10,000 in 2013. In 2011, significant progress was made to scale up treatment with over 7,000 fistula surgeries directly supported by UNFPA, a 40 per cent increase from 2010. Figure 16 highlights some of the countries that have seen expanded numbers of surgeries in the last three years, with support from UNFPA.

Many UNFPA country offices worked through security challenges, including Somalia, which directly supported 41 repair surgeries. Yemen established a new fistula unit in Aden Al-Wahda hospital. Beyond the Maternal Health Thematic Fund, UNFPA supported 115 fistula repairs

FIGURE 16

Trends in the number of women and girls surgically treated for fistula from 2009 2011 with UNFPA support



[14] United Nations Population Fund, *State of the World Population 2010*, New York: UNFPA. Available at: http://foweb.unfpa.org/SWP2011/reports/EN-SWOP2011-FINAL.pdf

in Angola, 180 repairs in the United Republic of Tanzania, and trained 17 doctors and health professionals in Gabon. Cambodia and Madagascar held national fistula campaigns for the first time, which resulted in outreach to 1,553 people and four fistula repair surgeries in Cambodia; 14 doctors were trained and 104 fistula repair surgeries were carried out in Madagascar.

Several countries successfully increased their capacity to treat fistula through the training of more than 1,300 health professionals in fistula management; 15 countries expanded the number of functioning referral centres (see Figure 17). The Aberdeen Women's Centre in Sierra Leone established a fistula 'hotline' in October 2011 with support from the Maternal Health Thematic Fund. Over 170 calls have since been received, which led directly to the identification and treatment of 220 fistula patients.

Fistula patients reintegrate back into their communities

Experience shows that healing fistula requires more than a surgical intervention, since women living with fistula have endured enormous psychological and social trauma. In 2011, UNFPA directly supported over 2,700 women and girls survivors of fistula reintegrate back into their communities; it also provided support to more than 70 facilities offering reintegration services. Nearly 60 per cent of campaign countries are now working to ensure that women and girls have access to rehabilitation and reintegration services (Figure 18), compared to 25 per cent in 2009.

The majority of these activities include business or life skills training in partnership with civil society and NGOs. For example, Niger provided training in income-generation and seed funding to 424 women who had received fistula repair surgery. This was in partnership with a local hospital and NGO. Similarly, the UNFPA office in Guinea partnered with the Association of Women Technologists and Technicians to offer business training and small-scale funding to help former fistula patients start their own businesses.

Another critical component of reintegration is counselling—before, during and after care. In 2011, Afghanistan trained more than 60 health workers on providing psychosocial support and counselling for fistula patients. In Nepal, counsellors followed up on 58 recovering fistula patients through home visits and telephone calls; they determined that 75 per cent of the patients successfully reintegrated into society.

With the Ministry of Health's full support, Liberia became a pioneer and role model in rehabilitation and reintegration services. In the last three years, 169 treated fistula patients

FIGURE 17

Number of functioning referral centres for fistula treatment in 50 countries supported by UNFPA, 2006-2011

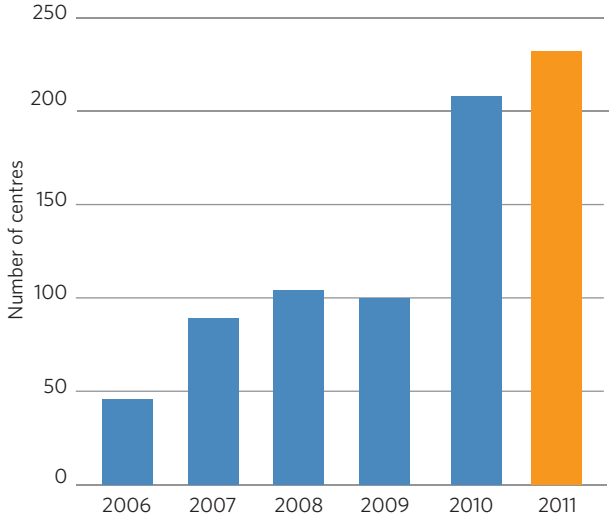
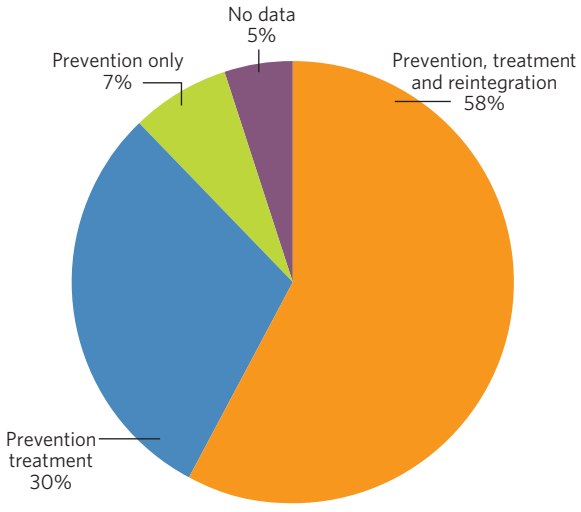


FIGURE 18

Proportion of countries in the Campaign to End Fistula offering key services in 2011



have received training in various skills, including literacy, business management and interior decorating. This year, a new rehabilitation centre opened with 27 participants completing their training cycle and returning home with renewed hope and restored dignity.

Research activities broaden knowledge about fistula

A number of countries are conducting research to better understand the burden and needs of women and girls suffering from fistula. Table 6 highlights some of these activities and results achieved in 2011.

5. Quality maternity care

Ensuring quality of care is critical for reducing maternal mortality and morbidity. It is also one of the key activities under Output 6 of the Maternal Health Thematic Fund Business Plan ('Monitoring and results-based management of national maternal and newborn efforts'). Quality of care is multidimensional, involving not only compliance to standards and norms, but patient satisfaction, availability of supplies and tools, and competencies, among other things. The MHTF has strategically chosen to focus on maternal death audits/reviews as one pillar in fostering a culture of continuous quality assurance in maternity care.

Key tools advanced to better manage maternity care

Maternal death audits/reviews follow the same rationale as quality assurance in manufacturing. They look beyond the number of deaths and study the causes and factors that could have helped to prevent each death. The findings naturally point to actions to improve the quality of care, focusing on specific and common problem areas. This section presents progress in advancing key tools to manage the quality of maternity care, including partography and active management of the third stage of labour, along with maternal deaths reviews.

Partographs are increasingly used to monitor labour

A partograph is used by midwives and others with midwifery skills to assess the progress of labour and to identify when an intervention is necessary. It is a proven and highly effective tool in reducing complications for the mother from prolonged labour (post-partum hemorrhage, sepsis, uterine rupture and its sequelae) and for the newborn (death, anoxia and infections, among others). It requires only a piece of paper on which the partograph is printed and a watch (Figure 19). An analysis of the use of partographs in eight countries where EmONC needs assessments were recently carried out (2010-2011) reveals a low quality of care during labour and delivery, demanding an urgent response (Figure 20).

TABLE 6. Research activities related to the burden of obstetric fistula completed in 2011 in selected countries

Country	Activity in 2011
Benin	Thirty professionals, including physicians, midwives and statisticians, were trained in the use of new tools for data collection on obstetric fistula.
Cameroon	A fistula module was integrated into the 2011 Demographic and Health Survey/Multiple Indicator Cluster Survey.
Ethiopia	Research was carried out on early bladder catheterization following prolonged labour in three hospitals.
Guinea-Bissau	An assessment survey was carried out on the results of 85 fistula repair surgeries and the skills of six fistula surgeons.
Lao People's Democratic Republic	A small-scale study on knowledge and awareness of fistula reveals a huge lack, both among medical professionals and the general public.
Mauritania	A national consultant is assessing the capacity of local NGOs working on sexual and reproductive health and reproductive rights.
Nepal	A rapid needs assessment of obstetric fistula in Nepal was conducted, focusing on four major institutions providing obstetric fistula care.
Multi-country	Johns Hopkins University continued working on a multi-country study (Bangladesh, Ethiopia and Niger) examining post-operative prognosis, improvements in quality of life, and social reintegration and rehabilitation of fistula patients after surgical treatment.

Use of partographs varies widely both within and among countries. In areas of Benin, for example, the use of partographs in health facilities is reported to be as high as 98 per cent; in the other countries shown in Figure 20, it averages 80 per cent or less and is as low as 34 per cent in Côte d'Ivoire. It should also be noted that these national averages mask huge disparities at the subnational and facilities level. In Burkina Faso, for instance, only 50 per cent of private hospitals consistently use partographs. Moreover, even when partographs are used, the necessary follow-up may be lacking. In Burundi, for instance, none of the facilities where partographs are reportedly used have a protocol for the management of labour.

Third stage of labour more actively managed

Another important quality of care tool is active management of the third stage of labour, which is a feasible, inexpensive and proven tool to prevent and manage postpartum hemorrhage—one of the leading causes of maternal mortality. The 2010-2011 analysis of quality delivery care tools in eight countries also revealed low levels of knowledge by the midwifery workforce in the management of labour. A quarter of the midwifery workforce in Benin, for example, lacks knowledge of controlled traction of the umbilical cord, and only 0.7 per cent and 2 per cent of the midwifery workforce in Burkina Faso and Côte d'Ivoire, respectively, scored correctly on questions involving interventions required during active management of the third stage of labour. The situation is similar in other countries and points to the need to strengthen the quality of care during labour and delivery in countries where maternal mortality is high.

The Maternal Health Thematic Fund is addressing quality of delivery care issues mainly though implementation of nationwide reviews of maternal deaths and training of midwives. The following three examples from Burundi, Benin and Côte d'Ivoire illustrate the support of the thematic fund to quality maternity care in countries where maternal mortality is high.

Burundi institutionalizes maternal death reviews

With support from the UNFPA country office, Burundi began institutionalizing maternal death reviews in 2011. The effort started in 11 referral hospitals and has gradually been scaled up to other referral and district hospitals. The following activities were carried out: development of a national maternal death review protocol and tools; development of an advocacy tool to engage stakeholders; training of trainers; training of district medical officers; and monitoring of all recommendations arising from the institutionalization of the reviews. Tangible outputs include: the development and validation of a standard

FIGURE 19

Sample of a partograph used by midwives to monitor labour

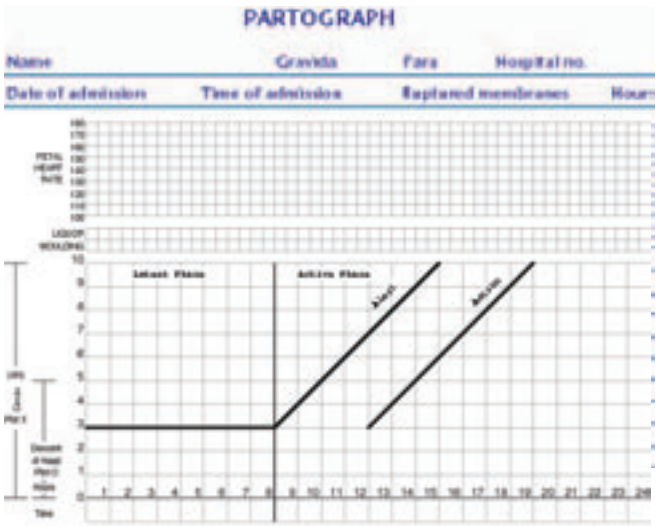
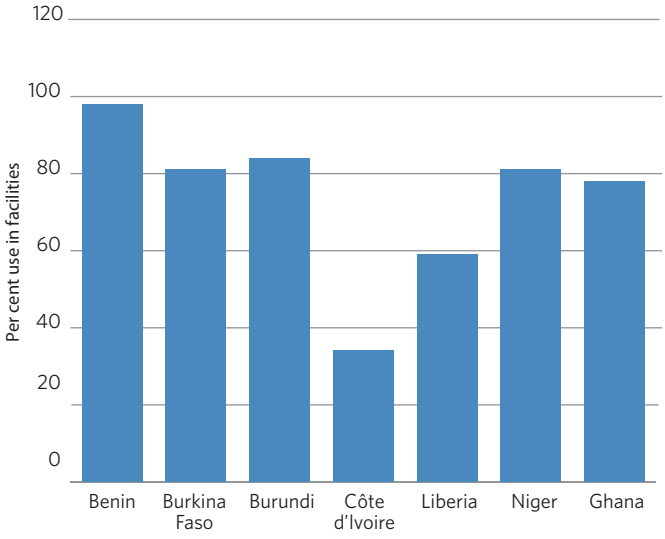


FIGURE 20

Use of partographs in seven MHTF-supported countries (percentage use in health facilities)



obstetric medical record for referral hospitals; inclusion of maternal death reviews in a minimum package of activities at the district hospital level; inclusion of a new indicator on maternal deaths in the National Health Information System; development of training materials; and registration and insertion of magnesium sulfate into the country's list of essential medicines.

Benin seeks reduction in abortion-related deaths

In Benin, the Ministry of Health is working with UNFPA and the Benin Association for the Promotion of Family Planning to enhance the capacity of midwives to provide post-abortion care to save women's lives. Many abortions are clandestine and performed under unsafe conditions in developing countries and, in Benin, abortion is a major cause of maternal death.

The scarcity of trained medical personnel in Benin places women at risk from unsafe abortion. In response, UNFPA is supporting the Government's effort to increase access to and uptake of quality services for the reduction of maternal mortality and morbidity due to abortions at the community and peripheral levels, and to reduce referrals to hospital.

Using the results of the EmONC needs assessment in 2010, UNFPA increased its evidence-based advocacy at the Ministry of Health. Under the leadership of the Ministry of Health, training of trainers was subsequently organized for midwives. Supplies and equipment were also provided, 15 midwives were trained in one health district, and a supervision team was put in place. In only four months, 20 cases of incomplete abortion were identified and handled successfully at health facilities by trained midwives. These 20 cases could well have resulted in death had the post-abortion services not been available. By shifting care often provided by obstetricians and medical doctors to highly-skilled midwives, more women can receive life-saving reproductive health services.

Midwife Eunice listens to a fetal heartbeat in Uganda.
Photo by Martin Caparros

Côte d'Ivoire revamps its reproductive health services

A more holistic approach that takes into account all dimensions of quality of care is the reorganization of reproductive health services (Box 2). Such a reorganization was carried out in Côte d'Ivoire and aimed to make a complete package of quality healthcare services available, thus improving accessibility to reproductive health. This was achieved by:

- Making an inventory of health facilities that require reorganization (a needs assessment);
- Improving clinical and management skills of staff;
- Establishing and implementing standards, norms and procedures in reproductive health;
- Strengthening the capacity of health services in terms of medical supplies and essential medicines;
- Establishing a system that fosters integration of reproductive health services;
- Strengthening the referral system.

By the end of 2011, 68 health facilities in Côte d'Ivoire had carried out a situation analysis, and 49 had begun implementation of their action plans. The results have been very encouraging: a 95 per cent increase in at least four antenatal care visits and a 25 per cent increase in institutional delivery across 11 health facilities in the Toumodi District between 2010 and 2011.

6. Maternal mortality surveillance and response

Due to the lack of complete and reliable data in low-income countries, levels and trends in maternal mortality have long been generated through modeling exercises based on survey results. The resulting maternal mortality ratios are generated periodically, have very wide confidence intervals and reflect situations five to 10 years prior to the surveys. What is needed, as indicated in the Maternal Health Thematic Fund Business Plan, is a surveillance approach that reflects maternal deaths in real time. Surveillance involves systematic notification of pregnancy-related deaths, continuous analysis of the causes and geographic distribution of these deaths, and the use of that information to inform and evaluate public health practices. Real-time monitoring is needed

Box 2. Ten steps to re-organizing reproductive health services in Côte d'Ivoire

Step 1: Engage all stakeholders (political, administrative and medical community leaders), building ownership and commitment

Step 2: Conduct a situation analysis in partnership with a national institution, such as the school of public health, thereby building national capacity

Step 3: Encourage the participation of stakeholders, primarily health workers, in the development and validation of an operational plan

Step 4: Upgrade skills and competencies in areas including reproductive health norms, standards and procedures such as record-keeping, workplace management, staff shifts, supplies and tools, and supervision

Step 5: Procure reproductive health supplies and equipment

Step 6: Develop and post organizational charts, supply identification plates for units and sections within the health facility

Step 7: Redeploy staff to match population needs, re-organize activities to better serve clients and reduce administrative burden

Step 8: Ensure environmental health in terms of cleanliness and hygiene

Step 9: Demonstrate and promote accountability and transparency within the units

Step 10: Carry out monitoring and supervision.

if accountability at the country level is to be achieved and maternal deaths are to be reduced significantly as a public health burden.

UNFPA has fostered the adoption of maternal death surveillance and response (MDSR) as a framework for the elimination of maternal mortality through the Commission on Information and Accountability for the UN Secretary-General's Global Strategy for Women's and Children's Health. In addition, a system called integrated disease surveillance and response has been updated to include maternal deaths.

Real-time monitoring of maternal deaths scaled up

In September 2011, UNFPA supported Mali in launching such a system for the surveillance of maternal and newborn deaths in the regions of Koulikoro and Segou. Box 3 presents preliminary results.

Real-time monitoring will be scaled up in Mali in 2012 and implemented in other countries, such as Benin, Ghana, Madagascar, Rwanda and Sierra Leone.

7. Support for family planning

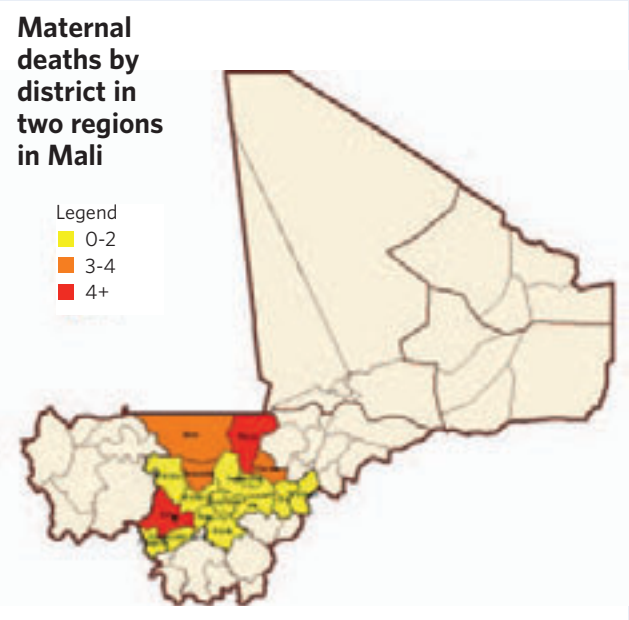
Given the scope of UNFPA's other thematic fund—the Global Programme to Enhance Reproductive Health Commodity Security—support to family planning by the Maternal Health Thematic Fund is limited to specific areas. These include: global, regional and country-level advocacy; technical guidance to address policy issues; neglected areas such as post-partum family planning; comprehensive family planning assessments in countries; and community mobilization at the country level.

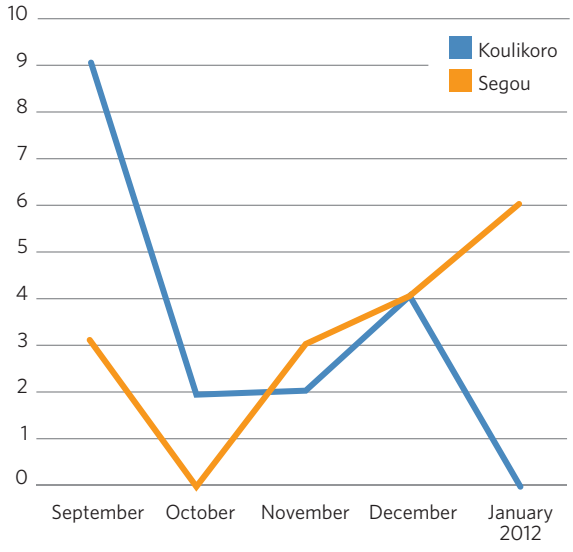
Box 3. Surveillance of maternal and newborn deaths at home in two regions of Mali

These very simple graphs provide real-time information on maternal and perinatal deaths in the Koulikoro and Segou regions of Mali over the course of five months.

An analysis of subnational and monthly trends suggests where and when the burden of maternal and perinatal death is highest. This has implications for appropriate prevention measures and adjustments in the management of human resources and equipment.

Access to such information can provide the direction and data needed to encourage greater accountability among district and regional health management teams and the incentive to improve the quality of maternity care in a context of increasing decentralization.





Major conferences spotlight urgency of family planning

In February 2011, UNFPA supported the participation of policy makers, parliamentarians, civil society groups, ministry of health officials and UNFPA representatives in a high-level conference on family planning in Ouagadougou, Burkina Faso. 'The West Africa Regional Conference—Population, Development and Family Planning: The Urgency to Act' was organized by the French Ministry of Foreign Affairs and USAID, and included country teams from Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo. Follow up included support to priority Francophone countries in West and Central Africa. The Maternal Health Thematic Fund contributed financially and technically to these activities and outputs.

Later in 2011, the world's largest-ever conference on family planning was held in Dakar, Senegal. UNFPA highlighted the need for an integrated approach to health, the connections between maternal mortality and women's access to family planning, and the importance of addressing young people's needs. UNFPA's global and regional communication teams worked with organizers on messaging around the conference, and made sure the linkages were articulated in both the conference programme and in the strong media coverage of the issues. UNFPA led various side events, including two panel discussions: 'Key elements of successful programmes that deliver family planning services through community health programmes' and 'Promoting family planning for post-partum women: Current recommendations, programme initiatives and future directions'. UNFPA also conducted an auxiliary session on integrating sexual and reproductive health services and a high-level ministerial meeting called 'Realizing the demographic dividend for the wealth and health of nations'.

Family planning assessments in four countries conclude

The year also saw the wrap-up of family planning assessments initiated in 2010 in Benin, Burkina Faso, Mali and Senegal. It culminated in a consultation organized by the Gates Foundation, USAID, UNFPA and others in April 2011 in Dakar, Senegal. Other UN agencies, donor institutions and NGOs, including WHO, the Population Council, Engender Health, the World Bank and the Japan International Cooperation Agency shared the results and identified priority actions of these assessments, thereby learning from successful experiences. Additional countries, such as Guinea, Madagascar, Mauritania, Niger, Togo and Rwanda were also invited to share good practices as well as experiences and lessons in scaling up family planning. Guinea subsequently expressed the need for a comprehensive family planning assessment, which will be completed in 2012.

8. Mobilizing communities for maternal health

Enhancing the prospects for maternal health hinges largely on strengthening national health systems through improvements in reproductive health and through the protection of women's rights. Of course, wider socio-cultural determinants also come into play and affect the outcome. These include gender inequalities, which can exacerbate the risks of maternal mortality and morbidity for women and girls. Support from the Maternal Health Thematic Fund enables UNFPA country offices to better address these risks by focusing on the most vulnerable groups, targeting child marriage, promoting girls' education (including comprehensive sexuality education) and using local advocates and champions (in the areas of fistula and maternal health, for example) to mobilize stakeholders. The MHTF has also fostered the adoption of key laws and policies by working with civil society, cultural gatekeepers, religious leaders and parliamentarians to advance women's rights, empowerment and gender equality. The following are examples of what such support can achieve.

Burundi's religious leaders promote reproductive health

Nearly 40 per cent of health services in Burundi are provided by faith-based organizations, and religious leaders are important gatekeepers in terms of reproductive health services. Under the leadership of the UNFPA country office, a series of advocacy and sensitization activities have been developed with political and religious leaders to address sexual and reproductive health needs. This advocacy has led to the inclusion of family planning in the country's second Poverty Reduction Strategy and National Health Development Plan for 2011-2015. The national demographic policy also takes into account access to and uptake of family planning.

Djibouti pioneers a community insurance scheme for maternal health

Since 2008, the UNFPA country office in Djibouti has supported the development of community health insurance for women in rural areas. Seventy-five women's groups are now benefitting from technical assistance in management and micro-finance, and receiving close supervision. The strategy aims to reduce financial barriers for maternal health and family planning and offer women a platform on which they can share experiences and build new skills.

Senegal engages mother-in-laws as agents of social change

To increase demand for family planning, the UNFPA country office in Senegal has identified mother-in-laws (*bajenu gox*) as agents of social change. In Senegalese society, mother-in-laws tend to be powerful advisers on reproductive health issues for young newlyweds and first-time mothers. By developing a work programme with them, UNFPA is seeking to build on the role of mother-in-laws as gatekeepers. It is also helping to ensure that young women receive adequate information and proper advice on issues such as family planning, sexuality education and maternal health. The acceptability of the programme has been enhanced by the involvement and endorsement of community and religious leaders.

Burkina Faso generates greater demand for maternal health services

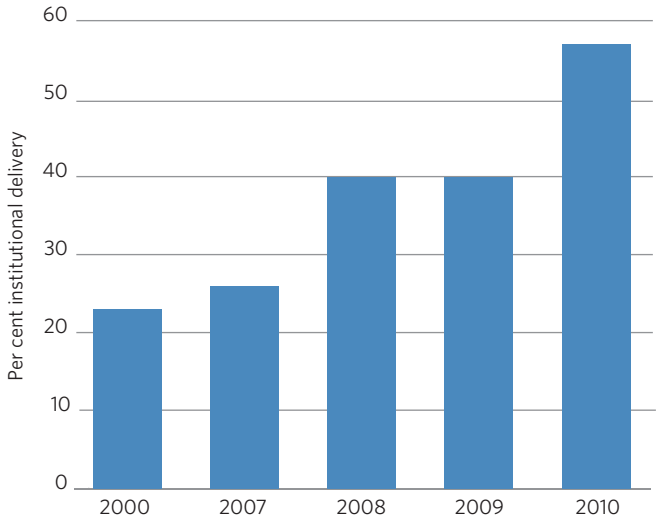
Burkina Faso's community engagement model in the Sahel region builds on partnerships with community leaders, local associations and community volunteers to promote skilled delivery, identify new fistula cases and hold communities accountable for improving maternal health outcomes. As part of the model, community relay agents are elected in each village and receive training on reproductive health, including family planning, as well as a budget for home visits and supplies. The project was initiated in 2008 and has since seen very positive results. In total, 63,450 people, including 34,000 women, have been sensitized to maternal health issues through a radio campaign, movies and local performances. In addition, 138 fistula cases were identified and reported; 113 of them were referred to hospital for care and treatment. The success rate for fistula repairs reached 89 per cent, and 16 out of 30 eligible fistula patients have received financial assistance to start small businesses. Data on institutional deliveries, released in 2012, shows a steady increase, as illustrated in Figure 21.

Countries use drama and mass media to promote maternal health

With support from the Maternal Health Thematic Fund, countries are using radio campaigns, film, new media and dramatic performances to generate demand at the community level for family planning and other aspects of maternal health. As a result, community and political leaders in the Central African Republic are engaged in identifying care and treatment for fistula survivors. In Bangladesh and Niger, mobile phones were provided to fistula advocates to improve coordination efforts and to elicit greater involvement with communities in their respective villages. In Senegal, a radio and television entertainment programme was developed to reach large audiences in that country. Sixty-six interactive radio shows were broadcast, which led to the identification and treatment of 62 fistula patients. In Sierra Leone, weekly radio dramas and television programmes about fistula were aired, reaching about 72 per cent of the population. In Ghana, a radio programme about fistula resulted in the submission of a proposal by the Department of Social Welfare to UNICEF and PLAN Ghana to cover transportation costs for fistula survivors involved in a UNFPA-supported programme. In Ghana, Kenya and Madagascar, short documentaries about fistula and maternal health were developed.

FIGURE 21

Percentage rise in institutional deliveries in the Sahel region of Burkina Faso, 2000-2010



9. Innovation

The use of mobile technology to improve maternal health was a focus of considerable attention in 2011. UNFPA is an active member of the Innovation Working Group of the 'Every Woman Every Child' initiative The Fund is also positioned as one of the thought leaders in the field, and its experts are widely consulted and quoted.[17] Media outreach about this and similar events included social media platforms and blogging.

Partnership with Intel poised to increase use of information technology to improve maternal care

UNFPA has developed an m-health project document and is leveraging partnerships with the private sector globally to increase access to quality maternity care through the use of information technology. A key example is a collaboration with the private sector global technology giant Intel. Initiated in 2011, the partnership is helping to strengthen the quality of and access to pre- and in-service training of midwives using e-learning modules, timely referrals, vital data registration and re-licensing using information and communication technologies, including high-speed Internet. A Memorandum of Understanding between Intel and UNFPA was signed in late January 2012.

Several country projects were initiated in 2011 to establish m-health monitoring of maternal and newborn deaths as well as stock-outs in contraceptives and essential medicines. The UNFPA office in Mali developed a partnership with the Orange Foundation (a mobile company) to support fistula patients as well as the monitoring of maternal and newborn deaths.

10. Evaluation

Ongoing evaluations will provide added clarity in moving forward

In 2011, UNFPA launched a mid-term evaluation of the Maternal Health Thematic Fund jointly with a thematic evaluation of UNFPA's support to maternal health overall. The latter was designed to assess the extent to which UNFPA's overall assistance—that is, UNFPA's support from all sources, including core resources, co-financing and all thematic funds—has been relevant, effective, efficient and sustainable in contributing to improvements in maternal health over the last decade. In contrast, the purpose of the MHTF evaluation is to review the effectiveness of its technical support. This encompasses programmatic directions (including technical capacities); design and focus; internal coordination and management mechanisms, relevance, effectiveness (programme delivery), efficiency and sustainability. The inception phase, desk phase and field phase have been completed; country cases studies (Burkina Faso, Cambodia, Democratic Republic of the Congo, Ethiopia, Ghana, Lao People's Democratic Republic, Liberia, Madagascar, Kenya and Zambia) as well as final reports are now being finalized.[18] These evaluations will shed light on the most efficacious ways to move forward in support of maternal health in priority countries.

[17] See media coverage of the Guardian Activate Summit in New York, during which experts discussed innovations in the context of UNFPA-supported maternal health projects: http://www.guardian.co.uk/activate/video/activate-new-york-sennen-hounton

[18] It should be noted that the Campaign to End Fistula will not be evaluated since an external evaluation of the campaign was completed in 2010.

Resources and management

The work of the Maternal Health Thematic Fund is supported largely by two multi-donor thematic trust funds: The Thematic Fund for Maternal Health and the Thematic Fund for Obstetric Fistula.

Thematic trust fund for maternal health

Contributions

As indicated in Table 7, total contributions for maternal health received during 2011 amounted to $11.3 million, compared to $22.7 million in 2010. The decline is largely attributed to the ongoing global financial crisis. Nevertheless, prudent financial planning has ensured accelerated implementation of the work of the MHTF. Moreover, donor pledges for 2012 are robust and better financial health is thus expected in 2012.

Out of a total $11.3 million, $9.5 million came from three major donors and was received during the fourth quarter of 2011; those funds will therefore be used for the implementation of programmes in 2012.

Operating budget

The effective working budget for maternal health in 2011 was $27.2 million (Table 8), an increase of 22 per cent over the 2010 budget of $22.3 million. The 2011 operating budget represents contributions received during the fourth quarter of the previous year ($18.2 million), rollover funds ($7.2 million), and contributions received during the first three quarters of 2011 ($1.8 million). In spite of decreasing income in 2011, the MHTF was able

TABLE 7. Total contributions for maternal health received in 2011

Donors	Contributions (US$)
Americans for UNFPA	8,577
Ireland[1]	1,333,333
Luxembourg	1,605,634
Netherlands[1]	2,427,940
Norway[1]	2,804,787
Private contributions	1,666
Sweden[1]	2,893,937
United Kingdom	202,670
Total 2011	**11,278,544**

[1] Contributions received during the fourth quarter of 2011

TABLE 8. Operating budget for maternal health activities in 2011

Donors	Contributions (US$)
Carry-over from 2010	25,349,615
Americans for UNFPA	8,577
Luxembourg	1,605,634
Private contributions	1,666
United Kingdom	202,670
Total 2011	**27,168,162**

A midwife kisses the cheek of a healthy, newborn baby in Cameroon.

Photo by Caroline Kilo Bara, UNFPA

FIGURE 22

Operating budget for maternal health in 2010 and 2011 (in US$ millions)

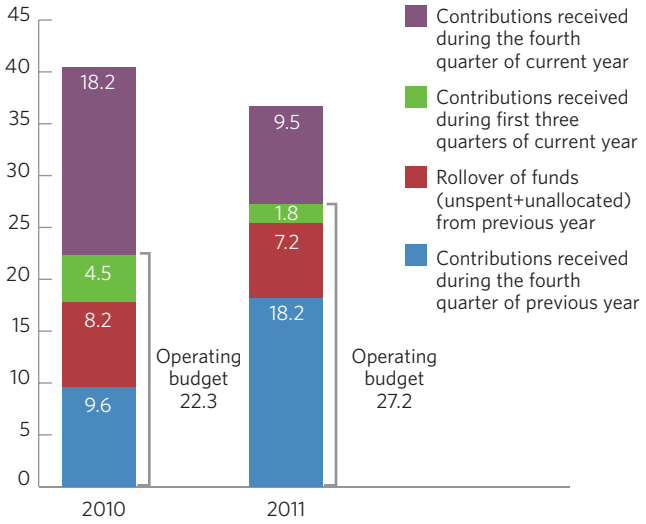
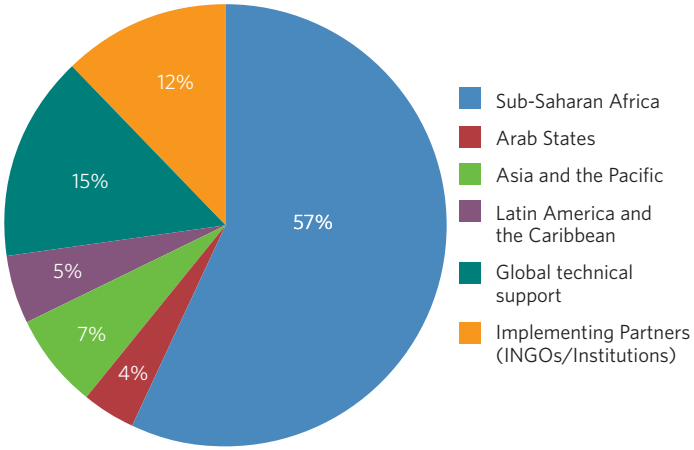


FIGURE 23

Share of expenditures for maternal health by region and globally, including implementing partners, in 2011 (per cent)



to establish an operating budget at an increased level of $27.2 million, with the receipt of additional contributions from the governments of Sweden ($4.4 million) and Norway ($2.5 million) received in December 2010; in addition, a small percentage of the 2010 operating budget was withheld by the MHTF to meet financial contingencies in 2011.

Figure 22 explains how the operating budget for each year is established. It clearly indicates that the MHTF continues to rely heavily on contributions received in the fourth quarter of each year for the next year's planning process.

Expenditures

Total expenditures for maternal health in 2011 totalled $19.92 million, compared to $16.61 million in 2010. During 2011, country and regional programmes, including spending by international NGOs (INGOs) and institutions supporting country-level programme activities, accounted for 85 per cent ($16.85 million) of the total; the remaining 15 per cent ($3.07 million) represents spending on global programmes. This compares with 86 per cent ($14.33 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level, in 2010, and 14 per cent ($2.28 million) for global programmes. Figures 23 and 24 show the percentage of funds spent regionally and globally, including implementing partners, in 2010 and 2011.

As mentioned above, $19.92 million was spent in 2011 to achieve expected results in maternal health, against a total allocation of $22.66 million. This translates into a financial implementation rate of 88 per cent, compared to 84 per cent in 2010, and shows a rising trend of implementation—a welcome and encouraging sign for the thematic fund. Figure 25 shows the operating budgets, allocations and expenditures for maternal health in 2010 and 2011.

Support to regional and global programmes

In 2011, funds totalling $22.66 million were allocated to country, regional and global programmes in maternal health, compared to $19.71 million for 2010. Of the 2011 total, 82 per cent ($18.67 million) went to regional and country programmes, including INGOs and institutions supporting programme activities at the country level, compared to 83 per cent ($16.42 million) in 2010. Eighteen per cent ($3.99 million) was allocated to global programmes, compared to 17 per cent ($3.29 million) in 2010. In terms of regions, the greatest share of resources for maternal health—53 per cent ($12.05 million)—went to sub-Saharan Africa; Asia and the Pacific received 8 per cent ($1.73 million), Latin America and the Caribbean received 5 per cent ($1.18 million), and the Arab States received 4 per cent ($0.87 million). Table 9 shows approved allocations of maternal health funds, expenditures, and the financial implementation rate by region, by country and globally in 2011 and 2010.

FIGURE 24

Share of expenditures for maternal health by region and globally, including implementing partners, in 2010 (per cent)

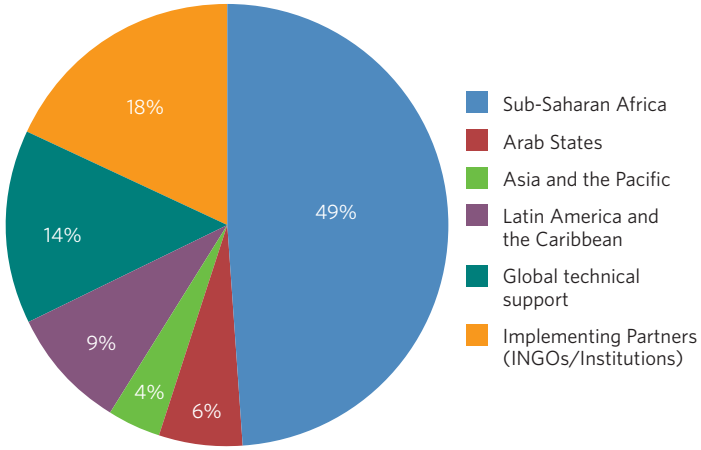


FIGURE 25

Operating budget, allocations and expenditures for maternal health in 2010 and 2011 (US$ millions)

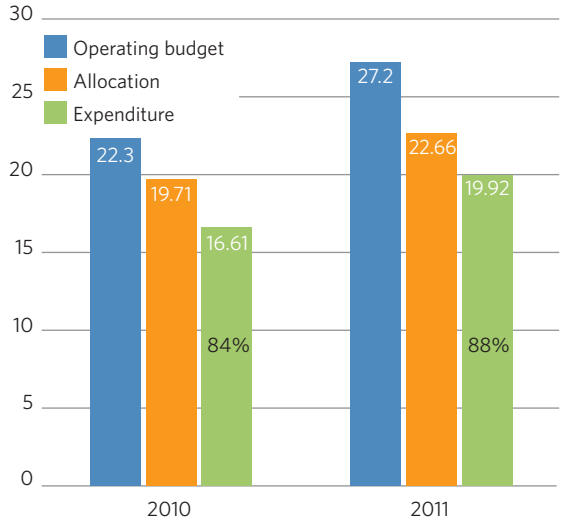


TABLE 9. Approved allocations, expenditures and financial implementation rate for maternal health in 2011 and 2010

	2011			2010		
Regional office/ country office/ global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**
Sub-Saharan Africa						
Africa Regional Office	328,000	205,655	63	300,000	302,048	101
Benin	800,000	783,498	98	862,819	870,912	101
Burkina Faso	750,000	679,791	91	600,000	498,496	83
Burundi	500,000	484,600	97	600,000	262,895	44
Chad	800,000	793,375	99	400,000	432,813	108
Côte d'Ivoire	1,000,000	995,189	100	375,000	376,516	100
Democratic Republic of the Congo	1,200,000	1,145,932	95	1,114,000	677,916	61
Ethiopia	2,000,000	1,924,213	96	2,000,000	1,970,716	99
Ghana	498,000	437,593	88	300,000	273,043	91
Guinea	-	-	-	34,773	30,863	89
Liberia	232,190	227,787	98	400,000	356,372	89
Madagascar	875,000	878,257	100	500,000	499,616	100
Malawi	700,000	658,679	94	700,000	742,705	106
Mali	100,000	93,383	93	300,000	14,117	5
Mozambique	200,000	190,580	95	200,000	67,616	34
Namibia	65,000	61,552	95	64,200	67,395	105
Niger	200,000	179,456	90	150,000	127,852	85
Nigeria	370,000	332,095	90	300,000	37,171	12

(continued)

TABLE 9. Approved allocations, expenditures and financial implementation rate for maternal health in 2011 and 2010 *(continued)*

Regional office/ country office/ global technical support/ partners	2011 Approved allocation (US$)	2011 Expenditure (US$)	2011 Implementation rate (%)	2010 Approved allocation (US$)	2010 Expenditure (US$)	2010 Implementation rate (%)
Rwanda	100,000	62,581	63	100,000	58,691	59
Sierra Leone	500,000	419,607	84	200,000	185,234	93
South Sudan	400,000	428,668	107	400,000	376,452	94
Uganda	129,000	128,072	99	125,000	111,256	89
Zambia	300,000	247,543	83	100,000	101,365	101
Sub-Saharan Africa total	**12,047,190**	**11,358,108**	**94**	**10,125,792**	**8,442,062**	**83**
Arab States						
Djibouti	400,000	319,979	80	600,000	365,886	61
Sudan	400,000	374,295	94	200,000	210,260	105
Yemen	67,000	62,791	94	100,000	72,379	72
Arab States total	**867,000**	**757,065**	**87**	**900,000**	**648,525**	**72**
Asia and the Pacific						
Asia and the Pacific Regional Office	18,750	9,026	48	200,000	20,324	10
Afghanistan	750,000	516,387	69	-	-	-
Bangladesh	100,000	93,519	94	200,000	154,066	77
Cambodia	300,000	251,346	84	337,419	301,558	89
Timor-Leste	100,000	102,212	102	-	-	
Lao People's Democratic Republic	300,000	286,749	96	200,000	196,093	98
Nepal	100,000	88,828	89	200,000	37,493	19
Pakistan	65,000	38,834	60	-	-	-
Asia and the Pacific total	**1,733,750**	**1,386,901**	**80**	**1,137,419**	**709,534**	**62**
Latin America and the Caribbean						
Latin America and the Caribbean Regional Office	25,000	25,680	103	110,000	110,256	100
Haiti	750,000	576,188	77	1,353,500	1,049,113	78
Guyana	400,000	357,196	89	400,000	406,099	102
Latin America and the Caribbean total	**1,175,000**	**959,064**	**82**	**1,863,500**	**1,565,468**	**84**
Global technical support						
Global technical support, including implementing partners	6,705,251	5,337,131	80	5,416,942	5,054,647	93
Information and External Relations Division	-	-	-	30,000	15,063	50
Media and Communications Branch	131,250	119,063	91	234,790	174,330	74
Global technical support total	**6,836,501**	**5,456,194**	**80**	**5,681,732**	**5,244,041**	**92**
GRAND TOTAL	**22,659,441**	**19,917,333**	**88**	**19,708,443**	**16,609,630**	**84**

As UNFPA's 2011 financial closure is still in process, all financial figures in this report are provisional until actual expenditure is reflected in the certified financial report.

Thematic trust fund for obstetric fistula

Contributions

Contributions received during 2011 for obstetric fistula totalled $0.86 million, compared to $1.70 million in 2010 (Table 10). The decline in income can be explained in part by the global economic situation. In addition, a number of donors are now funding comprehensive maternal health, which includes support to fistula programmes.

TABLE 10. Total contributions for obstetric fistula received in 2011

Donors	Contributions (US$)
Americans for UNFPA[1]	28,153
Iceland	71,612
Luxembourg	704,225
Poland[3]	40,000
Private contributions[2]	12,998
Total 2011	**856,988**

[1] Contributions received from individuals in the United States of America.
[2] These private contributions were made by individuals directly to UNFPA.
[3] Contributions received in the fourth quarter of 2011.

It is also important to note that several private sector donors have provided earmarked funds outside of the Thematic Fund for Obstetric Fistula to support fistula programmes at the country level. For example, Zonta International gave $375,000 for Liberia ($500,000 in total was awarded over two years); Virgin Unite gave $231,615 for Nigeria (a total of $1,032,500 was awarded over three years); Johnson & Johnson gave $160,000 ($80,000 for Côte d'Ivoire and $80,000 for Liberia, received in the fourth quarter of 2010 for 2011 programming); and the Women's Missionary Society-African Methodist Episcopal Church gave $25,000 for Malawi.

Operating budget

The effective working budget for obstetric fistula in 2011 was $6.14 million, a decline of 23 per cent from the 2010 operating budget of $7.92 million (Table 11). The budget for 2011 reflects contributions received during the fourth quarter of 2010 ($0.84 million), rollover funds ($4.48 million), and contributions received during the first three quarters of 2011 ($0.82 million). In view of the lower level of contributions for 2011, the Thematic Fund for Obstetric Fistula was able to establish an operating budget of only $6.14 million. Rollover funds ($4.48 million) include unspent balances from 2010 allocations to regions and countries (the financial implementation rate for 2010 was 72 per cent), along with unspent balances from prior years from other projects pooled for the fistula programme in 2011. These funds are treated as adjustments and are not considered as contributions received during the year.

TABLE 11. Operating budget for obstetric fistula for 2011

Donors	Contributions (US$)
Carry-over from 2010	5,317,104
Americans for UNFPA	28,153
Iceland	71,612
Luxembourg	704,225
Private contributions	12,998
Total 2011	**6,134,092**

Figure 26 shows how the operating budgets for 2010 and 2011 have been established. These budgets are the basis upon which the fistula programme is planned and implemented.

FIGURE 26
Operating budgets for obstetric fistula in 2010 and 2011 (US$ millions)

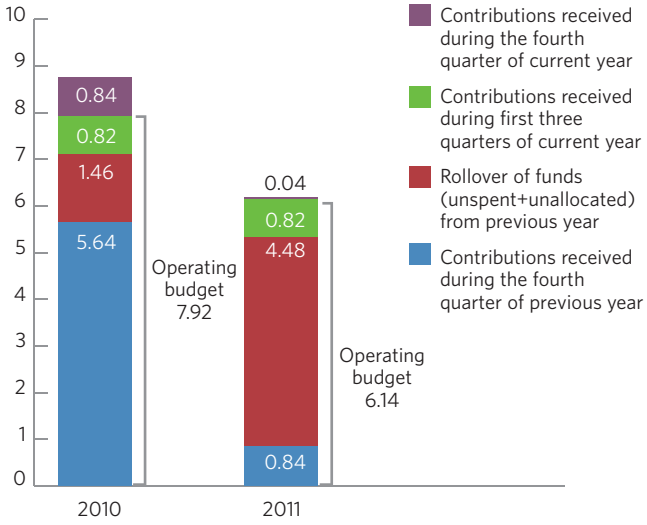


FIGURE 27

Share of expenditures for obstetric fistula by region and globally, including implementing partners, in 2011 (per cent)

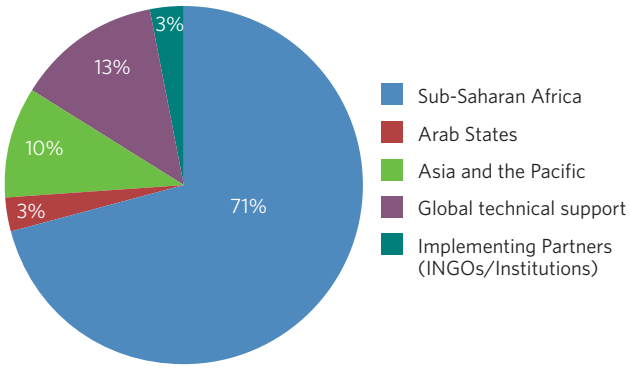
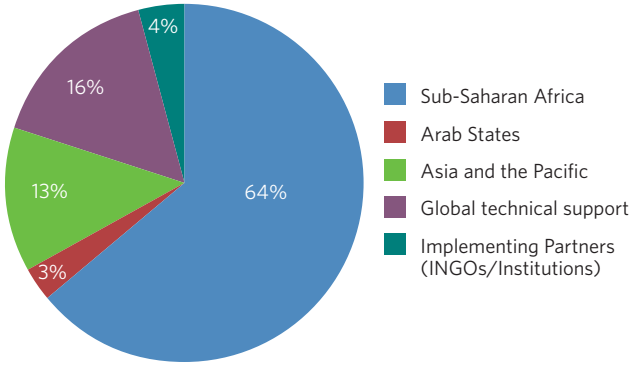


FIGURE 28

Share of expenditures for obstetric fistula by region and globally, including implementing partners, in 2010 (per cent)



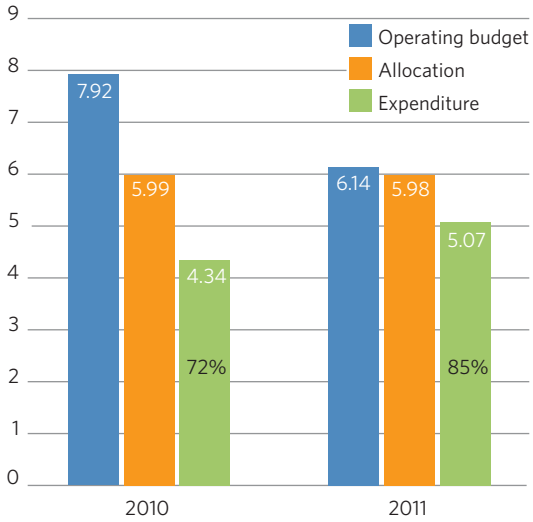
Expenditures

Total expenditures for obstetric fistula in 2011 totalled $5.07 million, compared to $4.34 million in 2010. During 2011, country and regional programmes, including spending by INGOs and institutions supporting country-level programme activities, accounted for 87 per cent ($4.40 million) of the total; global programmes accounted for 13 per cent ($0.66 million) of the total. This compares with 84 per cent ($3.66 million) for country and regional programmes, including expenditures by INGOs and institutions at the country level, in 2010, and 16 per cent ($0.68 million) for global programmes. Figures 27 and 28 show the percentage of funds spent by region and globally, including implementing partners, in 2011 and 2010.

As mentioned above, $5.07 million was spent to achieve planned results for the obstetric fistula programme in 2011, against a total allocation of $5.98 million. This translates into a financial implementation rate of 85 per cent, a clear improvement compared to 2010, which had an implementation rate of 72 per cent. Figure 29 shows operating budgets, allocations and expenditures for obstetric fistula in 2010 and 2011.

FIGURE 29

Operating budgets, allocations and expenditures for obstetric fistula in 2010 and 2011 (US$ millions)



Support to regional and global programmes

In 2011, allocations to country, regional and global programmes for obstetric fistula totalled $5.98 million, compared to $5.99 million in 2010. Regional and country programmes, including INGOs and institutions supporting country-level activities, represented 87 per cent ($5.19 million) of the total in 2011, compared to 89 per cent ($5.31 million) in 2010; global programmes represented 13 per cent ($0.79 million) of the total in 2011, compared to 11 per cent ($0.68 million) in 2010. By region, sub-Saharan Africa received the lion's share of support at 70 per cent ($4.19 million), followed by Asia and the Pacific at 10 per cent ($0.57 million), and the Arab States at 3 per cent ($0.19 million). Table 12 shows approved allocations, expenditures and the financial implementation rate by region, by country and globally in 2011 and 2010.

TABLE 12. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2011 and 2010 *(continued on next page)*

	2011			2010		
Regional office/country office/ global technical support/ partners	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**	**Approved allocation (US$)**	**Expenditure (US$)**	**Implementation rate (%)**
Sub-Saharan Africa						
Africa Regional Office	204,000	110,062	54	428,000	7,806	2
Benin	200,000	188,402	94	307,190	228,772	74
Burkina Faso	150,000	136,994	91	50,000	46,701	93
Burundi	50,000	48,425	97	50,000	28,864	58
Cameroon	100,000	90,138	90	75,000	53,609	71
Central African Republic	100,000	97,641	98	100,000	98,915	99
Chad	200,000	192,479	96	125,000	129,109	103
Congo	175,000	157,153	90	182,000	96,560	53
Côte d'Ivoire	200,000	173,019	87	200,000	173,890	87
Democratic Republic of the Congo	300,000	286,879	96	543,380	455,937	84
Eritrea	42,800	26,217	61	125,000	103,942	83
Ghana	200,000	93,749	47	100,000	36,071	36
Guinea	140,000	139,802	100	100,000	67,281	67
Guinea-Bissau	100,000	95,331	95	75,000	74,862	100
Kenya	150,000	106,615	71	150,000	157,565	105
Liberia	210,469	207,332	99	200,000	119,919	60
Madagascar	200,000	194,276	97	175,000	165,902	95
Malawi	160,000	162,728	102	75,000	73,917	99
Mali	50,000	53,978	108	100,000	77,104	77
Mauritania	125,000	95,676	77	100,000	105,578	106
Mozambique	48,000	35,186	73	-	-	-
Niger	250,000	218,598	87	150,000	135,318	90
Nigeria	180,000	139,199	77	208,025	10,368	5
Rwanda	50,000	50,885	102	-	-	-
Senegal	200,000	162,814	81	100,000	96,597	97
Sierra Leone	100,000	94,500	95	-	-	-
South Sudan	100,000	41,610	42	150,000	57,212	38
Uganda	100,000	99,258	99	100,000	99,508	100
Zambia	100,000	98,771	99	100,000	90,220	90
Sub-Saharan Africa total	**4,185,269**	**3,597,717**	**86**	**4,068,595**	**2,791,528**	**69**
Arab States						
Somalia	12,500	7,480	60	75,000	46,706	62
Sudan	100,000	78,250	78	100,000	72,175	72
Yemen	75,000	62,113	83	50,000	32,689	65
Arab States total	**187,500**	**147,843**	**79**	**225,000**	**151,571**	**67**

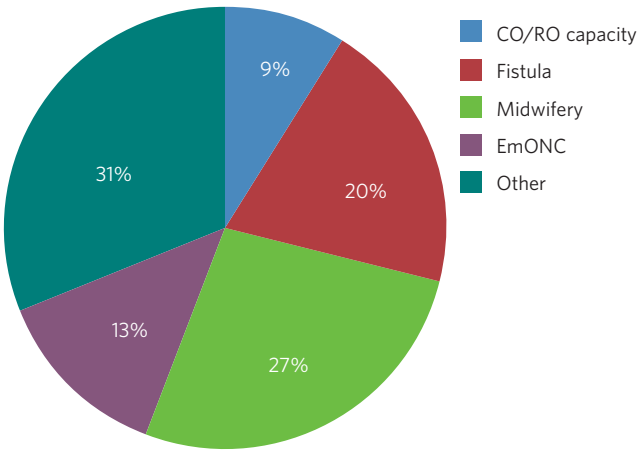
(continued)

TABLE 12. Approved allocations, expenditures and financial implementation rate for obstetric fistula in 2011 and 2010 (continued)

Regional office/country office/ global technical support/ partners	2011 Approved allocation (US$)	2011 Expenditure (US$)	2011 Implementation rate (%)	2010 Approved allocation (US$)	2010 Expenditure (US$)	2010 Implementation rate (%)
Asia and the Pacific						
Asia and the Pacific Regional Office	53,750	17,964	33	100,000	37,742	38
Afghanistan	100,000	120,037	120	300,000	244,862	82
Bangladesh	100,000	90,033	90	150,000	88,560	59
Cambodia	30,000	21,400	71	-	-	-
Timor-Leste	35,000	25,002	71	60,000	47,817	80
Nepal	50,000	38,485	77	50,000	25,711	51
Pakistan	200,000	199,965	100	200,000	114,916	57
Asia and the Pacific total	**568,750**	**512,886**	**90**	**860,000**	**559,607**	**65**
Global technical support						
Global technical support, including implementing partners	794,663	560,006	70	672,275	660,521	98
Information and External Relations Division	248,240	248,439	100	162,757	177,654	109
Global technical support total	**1,042,903**	**808,445**	**78**	**835,032**	**838,175**	**100**
GRAND TOTAL	**5,984,422**	**5,066,890**	**85**	**5,988,627**	**4,340,881**	**72**

As UNFPA's 2011 financial closure is still in process, all financial figures in this report are provisional until actual expenditure is reflected in the certified financial report.

FIGURE 30
Approximate distribution of MHTF resources in 2011



Linking results to financing

Linking resources to results in the area of maternal health remains challenging. Unlike commodities, maternal health activities often reflect more than one area of activity and are difficult to categorize. Figure 30 provides an approximate estimate of how MHTF resources are distributed. The exercise was made more difficult by the challenge of reporting at three levels (country, regional and global) and the need to avoid double-counting when specific activities synergistically cross more than one output. In fact, many activities at the country and regional levels are intrinsically linked and relate to several health system blocks. Nevertheless, the MHTF made an effort in 2011 to provide broad categories or areas of investment within the area of maternal health, including emergency obstetric and newborn care, midwifery, fistula (three new outputs defined in UNFPA's Strategic Plan) and other areas (including staffing for operations and strengthening of country and regional offices).

Nearly 27 per cent of MHTF resources in 2011 were specifically dedicated to midwifery, 20 per cent to fistula, 13 per cent to emergency obstetric and newborn care, and 9 per cent to the strengthening of country and regional offices. The category 'other' includes staffing for the MHTF's operation (nearly 8 per cent) and various maternal health activities. These include communication and advocacy, support to national reproductive health policy strategies and plans, maternal death audits and other quality of maternity care interventions, surveillance of maternal deaths, support to family planning (community mobilization), and support to civil society. In strengthening country and regional office capacity, the MHTF selectively responds to demands from UNFPA country representatives and regional directors by funding positions considered critical to reproductive health.

SECTION FOUR

Challenges and moving forward

The countries with the highest maternal mortality ratios are also the least developed countries with lower purchasing power, lower literacy rates and weaker systems of governance and accountability. Some of them are also embroiled in or recovering from conflict or other emergency situation. These are just some of the challenges encountered in managing and operationalizing the Maternal Health Thematic Fund, which are outlined below.

Challenges at the national level

Least developed countries: Where most maternal deaths and disabilities occur

Globally, the vast majority of maternal deaths occur in countries designated by the United Nations as 'least developed'. Some of the challenges in these countries are related to the social and political context resulting from a conflict situation (Côte d'Ivoire, Democratic Republic of the Congo, Madagascar, Mali, Nigeria); from a post-conflict situation (Sierra Leone, Liberia, Central African Republic); civil unrest (Benin); emergency (earthquake in Haiti, flood in Niger) or other challenges (Madagascar and Sudan). These factors cannot be controlled by development partners. Hence, planning for emergency preparedness must be an integral part of any sexual and reproductive health programming in a country.

The crisis in human resources

Other challenges relate to the issue of human resources at the country level. Simply put, skilled health workers are in very short supply, and are typically most scarce in geographic areas where the problems are greatest. This, together with low rates in the use of protocols, clinical guidelines and standard operating procedures, has had a profound impact on quality of care.

Particularly acute is the shortage of midwives. The lack of material, human and financial resources for midwifery has resulted in an insufficient number of skilled midwifery tutors along with clinical training opportunities for midwifery students. Moreover, the infrastructure needed for this training (schools, labs, hostels) is poor, and health workers with midwifery skills often lack motivation due to inadequate salaries and other forms of support. Similarly, the human resources needed for obstetric fistula repair and management, along with social rehabilitation, are insufficient. As a result, there is a growing gap between demand and supply for fistula services, the number of women and girls receiving support for social reintegration is not progressing as it should, and the capacity for assessing the quality of services and for providing follow-up care is weak. The services for inoperable and incurable cases are few and far between, made worse by the lack of reliable and comprehensive data on fistula.

◀ A treated fistula survivor shares a laugh with her supportive family member in the Democratic Republic of the Congo.

Photo by Women Deliver/Hamlin Fistula Hospital

Insufficient resources for achieving MDG5

The other major challenge faced by countries is the insufficiency of national financial resources for maternal health, stemming from its low priority. This problem is compounded by still low levels of official development assistance directed for MDG5.a and MDG5.b.

Building national and country office capacity

One of the key challenges facing least developed countries is the technical and managerial capacity of line ministries and para-governmental institutions, such as licensing boards. Where needed and viable, the MHTF is temporarily supporting some national units with critical staff, until such time that the ministry of health can take over. This is contributing to more rapid results while building national capacity.

Other challenges are related to the capacity of UNFPA country offices, which tends to be uneven across countries. Country office capacity depends in large measure on the leadership of the country representative and on the number and skill sets of staff. Some offices perform very well while others could be strengthened. One indication of country office performance is the rate at which they implement financial resources, including both core and thematic funds, and their ability to leverage additional resources at the country level for maternal health.

The Maternal Health Thematic Fund has been proactive in offering country office representatives funding for additional staff, including maternal health advisers, fistula focal points and country midwife advisers. Increasingly, it is doing so through joint funding with the Global Programme to Enhance Reproductive Health Commodity Security.

Another approach is to build the capacity of existing national programme officers on various themes pertaining to maternal health, such as communication, family planning, midwifery, fistula, maternal death reviews, and maternal mortality surveillance and response. One of the goals of the 2011 meetings in Accra and New Delhi, for example, was to bolster the capacity of midwifery advisers at the country level; the regional consultations in Pakistan and in Nepal had similar goals for obstetric fistula.

A third strategy is South-South cooperation to build capacity, in partnership with other international and local organizations, such as the Hamlin Hospital in Ethiopia, the Fistula Care project (Engender Health), the International Federation of Gynecology and Obstetrics and Columbia University, in the area of emergency obstetric and newborn care.

Given the growth of the maternal health programme, substantial additional financial resources are needed to train more fistula surgeons, establish fistula repair and social rehabilitation centres, train fistula survivors to become advocates, equip midwifery schools, develop the capacity of midwifery tutors, and upgrade emergency obstetric and newborn care services.

Challenges at the global level

Meeting the growing demand

A growing number of high-profile international partnerships and an improved social and political climate mean that opportunities to improve maternal health have never been better. At the same time, demand for support from the Maternal Health Thematic Fund is growing, both at the technical and communications level and in terms of human resources. The fund will continue its advocacy efforts to raise resources from both national governments and donors. It will also continue to foster partnerships with UN agencies, civil society and the private sector with support from donors.

In terms of monitoring and evaluation, a good deal of progress has been made since the inception of the Maternal Health Thematic Fund in 2008. In 2010, the second full year of operations, the MHTF produced a consolidated results framework. In collaboration with partners, it launched the first map of resources for fistula repair and social rehabilitation and the first global report on the state of midwifery. The thematic fund will continue to generate solid baselines for monitoring national progress on emergency obstetric and newborn care. It will also continue to track the effectiveness of its communications efforts through downloads from the UNFPA website, through the number of communication materials produced, and the number of feature stories on family planning, emergency obstetric and newborn care, midwifery and fistula appearing on global networks. However, we continue to 'live and learn'.

Box 4. Midwives: Helping to fill the human resource gap in maternal health

Despite growing recognition that investments in midwifery can have a major impact on reducing maternal and newborn death and disability, serious challenges remain. Most predominant is the fact that many countries still lack the policy environment needed to give midwives the authorization to practise basic lifesaving skills, resulting in poor training, retention and deployment policies. The Midwifery Programme will continue to engage with stakeholders to foster an appropriate policy response, as part of a comprehensive approach to strengthening health systems overall.

The second set of challenges relates to the paucity of resources—material, human and financial—available for the training of midwifery tutors, for clinical training opportunities for midwifery students, and for the schools, labs and hostels needed to carry out such training. Once midwives do receive the skills they need, poor salaries and a lack of incentives make them lose the motivation that drew them to the profession in the first place.

The Midwifery Programme will continue to advocate for additional resources from both national governments and donors to build the midwifery workforce. It will also encourage partnerships with UN agencies, civil society and the private sector to strengthen pre- and in-service training of midwives, using ICM/WHO competency-based curriculum, and to build the skills of midwifery tutors. Towards this end, and in collaboration with Jhpiego and WHO, UNFPA has forged an innovative partnership with Intel Corporation. The partnership will help to standardize e-learning, boost monitoring and reporting on maternal and newborn emergencies and deaths, and train faculty members and midwives seeking re-licensing using broadband technology for continuing education.

Moving forward

The Maternal Health Thematic Fund envisions a way forward based on four key actions.

1. **Update the Maternal Health Thematic Fund Business Plan following planned evaluations and donor consultations.** The findings and recommendations of the external MHTF mid-term evaluation and of the overall maternal health evaluation of UNFPA should be available during the second quarter of 2012. In consultation with donors, UNFPA will update the Maternal Health Thematic Fund Business Plan. As a central component of the plan, the fund will also produce a revised and more aligned results framework.

2. **Further strengthen the technical capacity of countries in greatest need.** The Maternal Health Thematic Fund will further strengthen the technical capacity of both selected countries and UNFPA country offices, as needed.

3. **Provide integrated technical and programmatic support using UNFPA's cluster approach.** To complement action 2 above, the Maternal Health Thematic Fund will further strengthen its technical and programmatic support to countries. This will be carried out in close collaboration with the Global Programme to Enhance Reproductive Health Commodity Security through UNFPA's new cluster approach, while fostering linkages between reproductive health and HIV for women and adolescents in 20 countries. The cluster approach is a mechanism through which UNFPA seeks to ensure a country-driven and country-led working modality to deliver on population and development. Two clusters have been created: the adolescent and youth cluster and the women's reproductive health cluster.

4. **Mobilize additional resources for sustained impact to meet the growing needs of the poorest countries.** Countries with high maternal mortality ratios are now better equipped technically than they were in 2008, when the Maternal Health Thematic Fund was launched. Many of them are poised to rapidly accelerate coverage of high-impact interventions. However, despite an improvement in their economic status, many of these countries do not yet have the domestic resource base to do so. Increased external financial resources are thus urgently needed to support scale up toward sustained impact.

Conclusion

The examples provided throughout this report show what the Maternal Health Thematic Fund has been able to achieve with only modest resources, through the combination of state-of-the-art technical support and the strengthening of capacity.

UNFPA welcomes the input of development partners and stakeholders to take stock of what has been learned to date, including through the external evaluation of the MHTF that is currently under way. It looks forward to similar collaboration in the development of an updated business plan and results framework.

With continued efforts by countries, development partners and UNFPA, including the work of its thematic funds, it is likely that we can realize the vision contained in the MHTF Business Plan and together can "envisage, in the not too distant future, a world where maternal mortality has been eliminated."[19]

[19] United Nations Population Fund, 2008, *Maternal Health Thematic Fund Business Plan 2008-2011*, New York, UNFPA, p. 36. Available at: http://www.unfpa.org/public/publications/pid/3085

Annex 1. Partners in the Campaign to End Fistula

1. Addis Ababa Fistula Hospital
2. African Medical & Research Foundation (Kenya)
3. African Women Solidarity Fund
4. American College of Nurse-Midwives
5. Babbar Ruga Fistula Hospital (Nigeria)
6. Bangladesh Medical Association
7. Bill and Melinda Gates Institute for Population & Reproductive Health
8. CARE
9. (US) Centers for Disease Prevention and Control
10. Columbia University's Averting Maternal Death and Disability Program
11. Direct Relief International
12. East Central and Southern Africa Association of Obstetrical and Gynecological Societies
13. EngenderHealth
14. Equilibres & Populations
15. Family Care International
16. Fistula Foundation
17. Fistula Foundation, Nigeria
18. Geneva Foundation for Medical Education and Research
19. Gynocare Fistula Center (Kenya)
20. Hamlin Fistula International
21. Healing Hands of Joy
22. Health and Development International
23. Health Poverty Action
24. Human Rights Watch
25. International Forum of Research Donors
26. International Confederation of Midwives
27. International Continence Society
28. International Federation of Gynecology and Obstetrics
29. International Urogynecological Association
30. International Society of Physicians and Surgeons
31. Johnson & Johnson
32. Johns Hopkins Bloomberg School of Public Health
33. London School of Hygiene and Tropical Medicine
34. Médecins Sans Frontières
35. Mercy Ships
36. Moi University (Kenya)
37. Mulagu Hospital/Medical School (Uganda)
38. Obstetrical and Gynaecological Society of Bangladesh
39. 'One by One' Project
40. Operation Obstetric Fistula
41. Pan African Urology Surgeon's Association
42. Population Media Center
43. Psychology Beyond Borders
44. Regional Prevention of Maternal Mortality Network (Ghana)
45. Selian Fistula Project (United Republic of Tanzania)
46. African Society of Obstetricians and Gynecologists
47. Société Internationale d'Urologie
48. South East Fistula Center (Nigeria)
49. The Association for the Re-orientation and Rehabilitation of Women for Development (TERREWODE) (Uganda)
50. Uganda Childbirth Injury Fund
51. UNFPA
52. United Methodist Church
53. United States Agency for International Development
54. University of Aberdeen (Scotland)
55. UZ Leuven (Belgium)
56. Voluntary Service Oversees
57. Virgin Unite
58. White Ribbon Alliance
59. Women's Dignity Project (United Republic of Tanzania)
60. Women and Health Alliance International
61. Women's Health Coalition
62. Women's Hope International
63. World Health Organization
64. Worldwide Fistula Fund

Annex 2. Consolidated results framework for 2011

	MDG5.a AND MDG5.b INDICATORS					
Countries with 3 years of MHTF support (M) and (F) indicate midwifery or fistula funding	a) Maternal mortality ratio	a) Skilled attendance at birth, %	b) Adolescent birth rate (per 1,000 women)	b) Antenatal care coverage, % (at least one/at least four visits)	b) Unmet need for family planning, %, total	b) Contraceptive prevalence rate, %, any method
Benin (M, F)	350	74	114	84.1/60.5	29.9	17
Burkina Faso (M, F)	300	53.5	131	85/17.6	28.8	17.4
Burundi (M, F)	800	33.6	30	92.4	29	9.1
Cambodia (M, F)	250	43.8	52.3	69.3/27	25.1	40
Côte d'Ivoire (M, F)	400	56.8	111.1	84.8/45.3	27.7	12.9
Djibouti (M, F)	200	60.6	27	92.3/7.1	-	17.8
Ethiopia (M, F)	350	5.7	109.1	27.6/12.2	33.8	14.7
Ghana (M, F)	350	57.1	70	90.1/78.2	35.3	23.5
Guyana (M)	280	83	32.6	100/41	36	11
Haiti (M, F)	350	26.1	68.6	84.5/53.8	37.5	32
Madagascar (M, F)	240	51.3	148	79.9/49.3	23.6	39.9
Malawi (M, F)	460	53.6	177	91.9/57.1	27.6	41
South Sudan (M, F)	730	14.7	34.5	9.5	23.9	1.7
Sudan (M, F)	730	49.2	72	63.7	26	7.6
Uganda (M, F)	310	41.9	159	93.5/47.2	40.6	23.7
Zambia (M, F)	440	46.5	151	93.7/60.3	26.5	40.8

MHTF OUTPUT 1 COUNTRY INDICATORS		MHTF OUTPUT 2 COUNTRY INDICATORS	MHTF OUTPUT 3 COUNTRY INDICATORS	
National comprehensive communication and advocacy strategy developed for sexual and reproductive health	Reproductive health coordination team in place, led by the ministry of health, and involving UNFPA and other partners	Up-to-date needs assessments for maternal and newborn health as part of national health plan, including emergency obstetric and newborn care, family planning, midwifery, and obstetric fistula services	Existence of a national development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care, is costed
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	–	–
✓	No	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	Partial	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
No	✓	✓	✓	No
No	No	✓	✓	✓
No	✓	No	✓	✓
Drafted	✓	✓	✓	✓

Annex 2. Consolidated results framework for 2011 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 3 years of MHTF support **(M) and (F) indicate midwifery or fistula funding**	**Midwifery training institutions with national midwifery curricula based on WHO/ICM essential competencies**	**Annual number of midwifery graduates from national midwifery training institutions**	**Midwives authorized to administer core lifesaving interventions (the 7 basic emergency obstetric and newborn care functions)**	**Midwives benefiting from systems for compulsory supportive supervision**	**Midwives benefiting from systems for continued professional education**
Benin (M, F)	1	0	✓	✓	✓
Burkina Faso (M, F)	3	270	✓	✓	✓
Burundi (M, F)	5	54	No	No	✓
Cambodia (M, F)	5	616	Partial	✓	✓
Côte d'Ivoire (M, F)	4	348	✓	✓	✓
Djibouti (M, F)	1	40	✓	✓	No
Ethiopia (M, F)	25	1640	✓	✓	✓
Ghana (M, F)	20	400	✓	✓	✓
Guyana (M)	5	176	✓	✓	✓
Haiti (M, F)	1	16	✓	No	✓
Madagascar (M, F)	0	300	✓	✓	✓
Malawi (M, F)	-	-	✓	✓	✓
South Sudan (M, F)	-	49	No	No	No
Sudan (M, F)	1	282	✓	✓	✓
Uganda (M, F)	Yes	393	✓	No	✓
Zambia (M, F)	13	505	✓	✓	Partial

MHTF OUTPUT 4 COUNTRY INDICATORS		MHTF OUTPUT 5 COUNTRY INDICATORS			
Country has a national midwifery council or board (stand-alone or included in nursing)	Number of health personnel trained in the management of fistula cases	Number of functioning treatment centres for fistula repairs	Number of treatment facilities that offer social reintegration services	Number of women surgically treated for obstetric fistula per year	Number of women treated for obstetric fistula who have been offered social reintegration
✓	270	3	0	124	59
✓	0	7	1	153	16
✓	2	1	0	57	0
✓	1	0	0	17	0
✓	118	6	4	237	17
No	3	2	0	10	0
No	101	11	11	274	-
✓	3	9	0	78	0
✓	0	0	0	0	0
No	4	-	-	-	-
✓	19	6	6	104	104
✓	13	8	3	178	0
No	3	0	0	6	0
✓	20 + 2 teams	8	4	529	428
✓	16	9	4	334	578
✓	4	5	0	187	0

(continued)

Annex 2. Consolidated results framework for 2011 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)							
Countries with 3 years of MHTF support **(M) and (F) indicate midwifery or fistula funding**	**Availability of basic emergency obstetric and newborn care: national number of facilities**	**Availability of comprehensive emergency obstetric and newborn care: national number of facilities**	**Geographic distribution: proportion of subnational areas with the required number of emergency obstetric and newborn care facilities, %**	**Proportion of all births in emergency obstetric and newborn care facilities, %**	**Met need for emergency obstetric and newborn care, %**	**Direct obstetric case fatality rate, %**	**Neonatal mortality (intrapartum and very early neonatal deaths)/ 1,000 deliveries**	**Proportion of births with Caesarian sections as a proportion of all births, %**
Benin (M, F)	7	22	7	16.2	6.8	1.4	–	4.6
Burkina Faso (M, F)	4	21	15	7.9 (urban 27, rural 0.5)	14.2	0.5	22	7.15
Burundi (M, F)	7	38	7.5	2.2	13.1	0.7	94	5.8
Cambodia (M, F)	36	31	2.2	18.3	29.32	0.52	37	3.15 (urban 8.2, rural 2)
Côte d'Ivoire (M, F)	1199	122	7	2.1	5	3	15	1.9
Djibouti (M, F)	30	5	–	31.6	–	–	–	14
Ethiopia (M, F)	140	65	4	10	7	2.8	62	1
Ghana (M, F)	111	76	–	21	17	2	30	7 (urban 11, rural 5)
Guyana (M)	–	–	–	–	–	–	–	–
Haiti (M, F)	–	12	–	–	60	–	37	3
Madagascar (M, F)	3	19	0	3	7.1	9.33	50.9	1.1
Malawi (M, F)	120	53	5	73	24	2	33	3.4
South Sudan (M, F)	–	0.5	–	12.3	–	–	–	0.5
Sudan (M, F)	–	–	–	20	–	–	–	–
Uganda (M, F)	–	–	–	–	–	–	27	–
Zambia (M, F)	232	56	68	–	–	–	23	3

MHTF OUTPUT 6 COUNTRY INDICATORS			MHTF OUTPUT 7 COUNTRY INDICATORS	
Mandatory notification and surveillance of maternal deaths	Routine practice of maternal death audits/ reviews	Confidential enquiries system for maternal deaths in place	Share of government expenditures for health, %, as per annual government figures	National budget for maternal and newborn health overall and per capita (including all flows, domestic and external), as measured through national health accounts where they exist, %/US$
✓	✓	✓	7.2 (2008)	–
✓	✓	No	15.5 (2009)	–
✓	✓	No	4.7 (2009)	–
✓	✓	–	–	–
No	No	No	5.1 (2009)	–
✓	✓	✓	14 (2011)	–
No	Partial	No	7	–
✓	✓	No	14 (2004)	–
✓	✓	No	6.7	–
✓	✓	✓	–	–
No	✓ (9 out of 40 facilities)	✓	8.7 (2010)	15.1 overall (2009)
✓	✓	✓	–	–
No	No	No	4.2 (2010)	6 overall (2010)
✓	In progress	In progress	4	1
✓	No	✓	6.5 (2011)	–
✓	✓	✓	13 (2011)	–

Annex 2. Consolidated results framework for 2011 *(continued)*

Countries with 2 years of MHTF support (M) and (F) indicate midwifery or fistula funding	MDG5.a AND MDG5.b INDICATORS					
	a) Maternal mortality ratio	a) Skilled attendance at birth, %	b) Adolescent birth rate (per 1,000 women)	b) Antenatal care coverage, % (at least one/ at least 4 visits)	b) Unmet need for family planning, %, total	b) Contraceptive prevalence rate, %, any method
Afghanistan* (M, F)	460	14.3	151	16.1	–	15.5
Bangladesh (M, F)	240	18	133	51.2/20.6	17.1	55.8
Cameroon (M, F)	690	63	141	82/60.4	–	29.2
Central African Republic (F)	890	53.4	132.9	69.3/39.7	16.2	19
Chad (M, F)	1100	14.4	–	–	–	–
Congo (F)	560	86.1	131.5	85.8/74.7	16.2	44.3
Democratic Republic of the Congo (M, F)	540	74	127	85.3/46.7	24.4	20.6
Eritrea (F)	240	28.3	85	70.3/40.9	27	8
Guinea (F)	610	46.1	153	88.4/50.3	21.2	9.1
Guinea-Bissau (F)	790	38.8	170	77.9	–	10.3
Kenya (F)	360	44	103	82/44	26	45.5
Lao People's Democratic Republic (M, F)	470	20.3	110	35.1	39.5	32.2
Liberia (M, F)	770	46.3	177	79.3/66	35.6	11.4
Mali (M, F)	540	49	190	70.4/35.4	31.2	8.2
Mauritania (F)	510	60.9	54	75.4/16.4	25	9.3
Mozambique (M, F)	490	55.3	185	89.1/53.1	18.4	16.5
Namibia (M, F)	200	81.4	74	94.6/70.4	6.7	55.1
Nepal (M, F)	170	18.7	106.3	43.7/29.4	24.6	48
Niger (M, F)	590	32.9	198.9	46.4/14.9	15.8	11.2
Nigeria (M, F)	630	38.9	123	57.7/44.8	20.2	14.6
Pakistan (M, F)	260	38.8	20.3	60.9/28.4	24.9	27
Rwanda (M, F)	340	52.1	43	95.8/23.9	37.9	36.4
Senegal (F)	370	51.9	96	87.4/39.8	31.6	11.8
Sierra Leone (M, F)	890	42.4	143	86.9/56.1	27.6	8.2
Somalia (F)	1000	33	123	26.1/6.3	–	14.6
Timor-Leste (M, F)	300	18.4	59.2	60.5/29.6	3.8	10
Yemen (M, F)	200	35.7	80	47/11.4	38.6	27.7

* An EmONC survey was conducted in Afghanistan in 2010, but indicators were not systematically calculated in accordance with the handbook on monitoring EmONC.

MHTF OUTPUT 1 COUNTRY INDICATORS		MHTF OUTPUT 2 COUNTRY INDICATORS	MHTF OUTPUT 3 COUNTRY INDICATORS	
National comprehensive communication and advocacy strategy developed for sexual and reproductive health	Reproductive health coordination team in place, led by the ministry of health, and involving UNFPA and other partners	Up-to-date needs assessments for maternal and newborn health as part of national health plan, including emergency obstetric and newborn care, family planning, midwifery, and obstetric fistula services	Existence of a national development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care	National development plan for an essential sexual and reproductive health package, including family planning, midwifery, obstetric fistula care, and emergency obstetric and newborn care, is costed
✓	✓	✓	✓	✓
✓	✓	No	✓	✓
No	No	✓	✓	✓
–	–	–	–	–
Draft	In progress	✓	✓	✓
–	–	–	–	–
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	No	✓	✓	✓
–	–	–	–	–
✓	✓	✓	–	–
No	✓	–	✓	✓
✓	✓	✓	In progress	✓
–	–	–	–	–
✓	✓	No	✓	–
No	✓	No	No	No
–	–	–	–	–
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
–	–	–	–	–
–	–	–	–	–
–	–	–	–	–
✓	✓	✓	✓	✓
–	–	✓	✓	✓
–	–	–	–	–
–	–	–	–	–
–	–	–	–	–

Annex 2. Consolidated results framework for 2011 *(continued)*

	MHTF OUTPUT 4 COUNTRY INDICATORS				
Countries with 2 years of MHTF support **(M) and (F) indicate midwifery or fistula funding**	**Midwifery training institutions with national midwifery curricula based on WHO/ ICM essential competencies**	**Annual number of midwifery graduates from national midwifery training institutions**	**Midwives authorized to administer core lifesaving interventions (the 7 basic emergency obstetric and newborn care functions)**	**Midwives benefiting from systems for compulsory supportive supervision**	**Midwives benefiting from systems for continued professional education**
Afghanistan (M, F)	34	–	Partial	No	No
Bangladesh (M, F)	3	–	No	No	–
Cameroon (M, F)	8	0	No	No	No
Central African Republic (F)	–	–	–	–	–
Chad (M, F)	23	250	✓	Partial	✓
Congo (F)	–	–	–	–	–
Democratic Republic of the Congo (M, F)	Yes	0	✓	–	–
Eritrea (F)	–	–	✓	✓	✓
Guinea (F)	1	69	✓	–	✓
Guinea-Bissau (F)	–	–	–	–	–
Kenya (F)	–	–	✓	✓	✓
Lao People's Democratic Republic (M, F)	8	160	✓	No	No
Liberia (M, F)	5	176	✓	✓	✓
Mali (M, F)	Yes	–	–	✓	–
Mauritania (F)	5	–	✓	No	✓
Mozambique (M, F)	–	–	–	–	–
Namibia (M, F)	–	–	–	–	–
Nepal (M, F)	–	–	✓	–	–
Niger (M, F)	17	–	✓	✓	✓
Nigeria (M, F)	–	–	–	✓	–
Pakistan (M, F)	–	–	–	–	–
Rwanda (M, F)	Yes	–	–	✓	–
Senegal (F)	100%	536	✓	✓	✓
Sierra Leone (M, F)	2	114	✓	–	–
Somalia (F)	–	–	–	–	–
Timor-Leste (M, F)	–	–	–	–	–
Yemen (M, F)	–	–	–	–	–

MHTF OUTPUT 4 COUNTRY INDICATORS			MHTF OUTPUT 5 COUNTRY INDICATORS			
Country has a national midwifery council or board (stand-alone or included in nursing)	Number of doctors trained in surgical obstetric fistula repair	Number of health personnel trained in the management of fistula cases	Number of functioning treatment centres for fistula repairs	Number of treatment facilities that offer social reintegration services	Number of women surgically treated for obstetric fistula per year	Number of women treated for obstetric fistula who have been offered social reintegration
No	–	86	1	0	72	0
✓	–	50	10	1	358	85
No	–	0	6	0	0	0
–	–	44	2	0	25	–
✓	–	7	4	1	150	0
–	6	18	4	2	26	35
No	–	130	30	–	473	253
No	–	–	2	–	94	–
No	–	65	5	3	112	51
–	–	5	2	1	85	85
✓	–	24	15	4	300	–
No	–	0	0	0	0	0
✓	–	105	2	1	244	27
–	–	10	5	1	482	30
✓	2	16	5	–	62	–
–	–	23	4	0	373	0
–	–	–	–	–	–	–
✓	13	40	3	0	73	58
No	5	7	6	7	382	424
–	–	–	3	3	600	118
–	–	57	15	4	395	70
–	–	7	–	–	47	–
✓	–	30	7	2	62	35
✓	–	20	2	2	220	220
–	–	–	1	–	41	–
–	–	27	1	0	6	0
–	–	0	1	0	6	0

Annex 2. Consolidated results framework for 2011 *(continued)*

	UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)			
Countries with 2 years of MHTF support **(M) and (F) indicate midwifery or fistula funding**	**Availability of basic emergency obstetric and newborn care: national number of facilities**	**Availability of comprehensive emergency obstetric and newborn care: national number of facilities**	**Geographic distribution: proportion of subnational areas with the required number of emergency obstetric and newborn care facilities, %**	**Proportion of all births in emergency obstetric and newborn care facilities, %**
Afghanistan (M, F)	–	–	–	15
Bangladesh (M, F)	–	–	–	–
Cameroon (M, F)	61	32	1	6.1
Central African Republic (F)	–	–	–	–
Chad (M, F)	23	20	10	4.6
Congo (F)	–	–	–	–
Democratic Republic of the Congo (M, F)	–	–	–	–
Eritrea (F)	32	12	–	32
Guinea (F)	13	13	–	–
Guinea-Bissau (F)	–	–	–	–
Kenya (F)	41%	–	3.4	41
Lao People's Democratic Republic (M, F)	5	9	14	24.9
Liberia (M, F)	1	9	6	9.9
Mali (M, F)	–	–	–	–
Mauritania (F)	–	–	–	–
Mozambique (M, F)	45	33	38 BEmONC/80 CEmONC	17
Namibia (M, F)	–	–	–	–
Nepal (M, F)	–	–	–	–
Niger (M, F)	44	29	12.5	23.2
Nigeria (M, F)	–	–	–	–
Pakistan (M, F)	–	–	–	–
Rwanda (M, F)	–	–	–	–
Senegal (F)	34	4	1	–
Sierra Leone (M, F)	0	14	1.2	2
Somalia (F)	–	–	–	–
Timor-Leste (M, F)	–	–	–	–
Yemen (M, F)	–	–	–	–

UN EMERGENCY OBSTETRIC AND NEWBORN CARE INDICATORS (PART OF OUTPUT 5 INDICATORS)				MHTF OUTPUT 6 COUNTRY INDICATORS		
Met need for emergency obstetric and newborn care, %	Direct obstetric case fatality rate, %	Neonatal mortality (intrapartum and very early neonatal deaths), per 1,000 deliveries	Proportion of births with Caesarian sections as a proportion of all births, %	Mandatory notification of maternal deaths	Routine practice of maternal death audits/ reviews	Confidential enquiries system for maternal deaths in place
20	87	29	1.1	No	No	No
–	–	–	–	No	No	No
34.8	2.08	31	2.3	No	No	No
–	–	–	–	–	–	–
4	6.7	39	0.50	No	–	No
–	–	–	–	–	–	–
–	–	–	5	✓	No	No
–	–	–		✓	✓	✓
–	–	–	2.4	No	No	✓
–	–	–	–	–	–	–
–	–	37 (2008/09)	–	✓	✓	✓
13.9	13	44	2.6	No		No
5.5	2.6	24	2.8	In progress	In progress	No
–	–	–	–	–	–	–
–	–	–	–	No	No	No
11	5.2	10	2.2	✓	✓	No
–	–	–	–	–	–	–
–	–	–	–	✓	✓	✓
19.6	2.7	79	1.4	✓	Partial	No
–	–	–	–	–	–	–
–	–	–	–	–	–	–
–	–	–	–	–	–	–
–	30	39	6	✓	✓	No
7	2.5	36	2	–	✓	In progress
–	–	–	–	–	–	–
–	–	–	–	–	–	–
–	–	–	–	–	–	–

Annex 2. Consolidated results framework for 2011 *(continued)*

	MHTF OUTPUT 7 COUNTRY INDICATORS	
Countries with 2 years of MHTF support **(M) and (F) indicate midwifery or fistula funding**	**Share of government expenditure for health, %, as per annual government figures**	**National budget for maternal and newborn health care overall and per capita (including all flows, domestic and external), as measured through national health accounts where they exist, %/US$**
Afghanistan (M, F)	6	10.29 (2008)
Bangladesh (M, F)	6.5 (2008/09)	–
Cameroon (M, F)	6	–
Central African Republic (F)	–	–
Chad (M, F)	5.3 (2010)	–
Congo (F)	–	–
Democratic Republic of the Congo (M, F)	–	–
Eritrea (F)	–	–
Guinea (F)	2.5	–
Guinea-Bissau (F)	–	–
Kenya (F)	0.8 (2009/10)	–
Lao People's Democratic Republic (M, F)	19 (2007)	–
Liberia (M, F)	6.7	–
Mali (M, F)	–	–
Mauritania (F)	10.7	–
Mozambique (M, F)	7 (2011)	–
Namibia (M, F)	–	–
Nepal (M, F)	5.3	11 overall
Niger (M, F)	6.14	10.3
Nigeria (M, F)	–	–
Pakistan (M, F)	–	–
Rwanda (M, F)	–	–
Senegal (F)	8.04	–
Sierra Leone (M, F)	8.2	32
Somalia (F)	–	–
Timor-Leste (M, F)	–	–
Yemen (M, F)	–	–

Annex 2. Health expenditures for all MHTF countries

Country	Government health expenditure as a share of general government expenditure (%)	Out-of-pocket expenditure as share of total health expenditure (%)
Afghanistan (M, F)	1.59	83.04
Bangladesh (M, F)	7.36	64.10
Benin (M, F)	9.62	46.77
Burkina Faso (M, F)	13.49	36.21
Burundi (M, F)	8.14	37.94
Cambodia (M)	10.48	40.39
Cameroon (F)	8.53	66.49
Central African Republic (F)	8.45	61.38
Chad (M, F)	3.27	72.55
Congo (F)	5.29	53.26
Côte d'Ivoire (M, F)	5.06	77.47
Democratic Republic of the Congo (F)	9.11	35.91
Djibouti (M, F)	14.15	34.39
Eritrea (F)	3.60	51.76
Ethiopia (M, F)	13.46	37.21
Ghana (M, F)	12.07	26.90
Guinea (F)	1.84	88.15
Guinea-Bissau (F)	4.14	66.43
Guyana (M)	-	-
Haiti (M, F)	4.51	NA
Kenya (F)	7.31	42.70
Lao People's Democratic Republic	5.90	51.15
Liberia (F)	11.10	35.24
Madagascar (M, F)	14.70	27.12
Malawi (M, F)	14.20	11.12
Mali (M, F)	10.58	53.15
Mauritania (F)	7.30	44.31
Mozambique (F)	12.19	13.65
Namibia	-	-
Nepal (M, F)	7.36	64.10
Niger (F)	11.13	41.31
Nigeria (F)	4.41	59.21
Pakistan (M, F)	3.63	50.48
Rwanda	20.08	22.16
Senegal (F)	11.56	34.95
Sierra Leone (M, F)	6.35	79.40
Somalia (F)	NA	NA
South Sudan (M, F)	NA	NA
Sudan (M, F)	9.76	67.16
Timor-Leste	-	-
Uganda (M, F)	12.11	49.77
Yemen (F)	4.32	74.79
Zambia (M, F)	15.64	26.49
Total no. of countries:	**43**	
Total no. of countries reporting:	**38**	
No. of countries with share >= 10%:	**15**	
No. of countries with share >= 15%:	**2**	

African Union member states	Government health expenditure as a share of general government expenditure (%)
Benin (M, F)	9.62
Burkina Faso (M, F)	13.49
Burundi (M, F)	8.14
Cameroon (F)	8.53
Central African Republic (F)	8.45
Chad (M, F)	3.27
Congo (F)	5.29
Côte d'Ivoire (M, F)	5.06
Democratic Republic of the Congo (F)	9.11
Djibouti (M, F)	14.15
Eritrea (F)	3.60
Ethiopia (M, F)	13.46
Ghana (M, F)	12.07
Guinea (F)	1.84
Guinea-Bissau (F)	4.14
Kenya (F)	7.31
Liberia (F)	11.10
Madagascar (M, F)	14.70
Malawi (M, F)	14.20
Mali (M, F)	10.58
Mauritania (F)	7.30
Mozambique (F)	12.19
Namibia	-
Niger (F)	11.13
Nigeria (F)	4.41
Rwanda	20.08
Senegal (F)	11.56
Sierra Leone (M, F)	6.35
Somalia (F)	NA
South Sudan (M, F)	NA
Sudan (M, F)	9.76
Uganda (M, F)	12.11
Zambia (M, F)	15.64
Total no. of countries:	**33**
Total no. of countries reporting:	**30**
No. of countries with share >= 10%:	**14**
No. of countries with share >= 15%:	**2**

The Maternal Health Thematic Fund: Accelerating Progress towards Millennium Development Goal 5

UNFPA's Maternal Health Thematic Fund (MHTF) provides strategic technical assistance and catalytic funding to countries most in need to accelerate progress towards Millennium Development Goal 5: Improve maternal health.

Launched in 2008, the MHTF has contributed to the following results in less than four years:

- ✓ **Maternal health is now high on the global and national agendas,** through communication and advocacy, joint efforts by the H4+ group, and support to the UN Secretary-General's 'Every Woman Every Child' initiative.
- ✓ **Needs assessments in emergency obstetric and newborn care have been carried out in 24 countries.** These help map the current level of care and provide the evidence needed for planning, advocacy and resource mobilization to scale up emergency services in every district.
- ✓ **Work is under way in 30 countries to strengthen and scale up the midwifery workforce,** a critical element in filling the human resource gap in maternal health. The first-ever *State of the World's Midwifery* report was also launched in 2011, providing data on the status of midwifery in over 50 countries.
- ✓ **Improvements in maternal and newborn health services are ongoing in 30 priority countries.** These efforts are already contributing to increased coverage of lifesaving care, and early reports suggest a decreasing number of maternal deaths in some of the health facilities receiving support.
- ✓ **Systems for real-time surveillance of maternal deaths and response are being promoted and instituted,** with the goal of fostering greater technical and political accountability.
- ✓ **More than 7,000 women received surgical fistula repairs in 2011 alone.** This is a direct result of UNFPA's work as a leader and major contributing partner to the Campaign to End Fistula.

These results were achieved with only modest resources—$25 million in 2011. But much more needs to be done if the lives of women and children are to be given the respect they deserve.

No woman should die giving life.

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